

***“I trust them when they listen”:***  
**The Utilisation of Health Care**  
**by Three Asian Ethnicities**

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## **Abstract**

New Zealand is a country populated by migrants and the Asian population is the largest fastest growing cohort and are predicted to outnumber Māori (i.e. the indigenous people of New Zealand) by 2050. Due to the requirements of immigration to New Zealand the Asian community tends to be highly educated, with Asian ethnicities being more likely to have a university bachelor or post-graduate degree. Asian people are distributed more towards lower household income categories than Europeans, but the proportion of Asian people living in the lowest New Zealand deprivation quintile areas has declined in recent years. Migrants applying for residency are required to have, and thus can be expected to arrive in the country, with good health.

The research on health care utilisation in geography has suffered by its tendency to neglect migration and culture as an influencing factor. In New Zealand this neglect is compounded by the near absence of a research focus on Asians and where they do appear it is in collated national surveys that have tended to group all sub-Asian ethnicities as one. This study explored the utilisation of health care from two directions. First, the response and perceptions of health care use from the view of the health services and, second, the perceptions of health care provision from the view of Asian migrants. For these reasons qualitative methods were utilised as they allow a focus on the everyday life situations of subjects. They provide opportunity to expand and flow with the research process.

In New Zealand, health services are available that specifically target Asian patients, but they are not uniformly available across New Zealand. This study identifies features of mainstream general practice services, as well as factors that migrants bring with them that act as barriers for Asian people accessing health services, including affordability, language and negative experiences that influence trust of the New Zealand health care system. In many cases affordability was linked to a perceived lack of value for money, where no treatment or

tangible outcome was received through a visit to the doctor. Language was indicated to be the most pressing barrier to accessing health care and participants' home country health experiences continued to influence perceptions and use of health care in New Zealand. The study also highlights some strategies that can be implemented into various stages of the Asian patient's introduction into and then through the health system and health care to improve the availability and acceptability of these services.

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## **Chapter 1 : Introduction**

### **1.1 Introduction**

I have lived and experienced a foreign health system first hand through 12 years teaching English as a second language in Japan. The health system in Japan is very different to that of New Zealand. Having to find the doctor for what I thought ailed me through some self-diagnosis was something new having come from a country where the first place to go when sick is the general practitioner (GP). Having to think this part hurts, so I need this kind of doctor, whilst not a challenge, was somewhat worrying. And to have to do this in Japanese was doubly so. While my ability with the Japanese language was fine for everyday get about town communication, to explain what kind of pain I was feeling was a challenge. Sharp pain, dull pain, throbbing pain, intermittent pain, constant pain.

In the twelve years I lived in Japan I had my wisdom teeth removed, I had a colonoscopy, I was taken through a hospital emergency department after a car accident and on other innumerable occasions I needed to wait in hospital outpatients departments. In Japan I first learnt I had only one kidney, probably since birth. I never had cause for complaint at the treatment. I did wonder at the number of small packets I would get just because I had a cold: one drug for one symptom, a second drug for another symptom and another to treat the side effects of the other drugs. Thankfully, I had my Japanese wife to guide me through it all. To explain why it was this way and not how it is in New Zealand. ‘Yeah, but in New Zealand...’

When we moved back to New Zealand from Japan my wife had to find a doctor. I had to do the same things all over for her. These experiences each of us had gone through caused me to wonder how this was for other Japanese people in New Zealand. What if they

did not have someone close to guide them through the differing system like we had done for each other? It is this that has lead me to this research project more than anything else.

Up until 1945 New Zealand had one of the most culturally homogenous populations in the world, centred on a dominant population of primarily British origin. However, in the last three decades this migrant source has come to be overtaken by Asian sourced migrants creating a much more culturally diverse country. Asian migration to New Zealand has been much discussed in the media and, in some corners, is politically charged.

The Asian population is the largest growing cohort of the population in New Zealand (Statistics New Zealand, 2010b). The Asian community tends to be highly educated, with Asian ethnicities being more likely to have a university bachelor or post-graduate degree than non-Asian groups. However, while Asian people, along with Pacific persons, are distributed more towards lower household income categories than European, the proportion of Asians living in the lowest New Zealand deprivation quintile areas has declined in recent years (Statistics New Zealand, 2010a). This Asian segment of the population is ethnically diverse and frequently ill-defined in the literature, notwithstanding the New Zealand definition that includes a geographical origin reference between Afghan and Japanese, and Chinese and Indonesians. Generally speaking, migrants applying for residency in New Zealand are required to have, and thus can be expected to arrive in the country, with good health.

With these health requirements it is not surprising Asian New Zealanders born in this country are in general less healthy than recent migrants across a range of health indicators and outcomes, including cardiovascular disease, cancer mortality. Contradicting such health outcomes long term Asian residents also feature a prevalence of health promoting behaviours, such as exercise, more than recent arrivals (Scragg, 2010). Further, Asian migrant groups frequently feature high levels of education, which is regularly correlated with better health

status. The positive consequence of the 'healthy migrant effect' on health abates with increased length of settlement in New Zealand and is something commonly reported in overseas studies.

A frequent feature in the literature, both in New Zealand and internationally, structures the Asian populations into a single grouping, limiting the understanding of the drivers towards utilisation of health care by smaller ethnic minorities (Kim and Keefe, 2010). This limitation in studies is important as cultural differences may determine the attitudes these minorities hold towards health care, thus influencing their health outcomes. It is this point of cultural differences of health care utilisation and health outcomes for minorities that is a leading factor for the interest in this research project. In New Zealand calls for a reconsideration of 'Asian' in health research have been made, particularly after the publication in 2006 of large scale reports that to some extent broke down the Asian ethnic group (into Chinese, South Asian/Indian and Other Asian) (Rasanathan et al., 2006a). In New Zealand no studies have looked at the utilisation of health care services by Japanese, nor have they broken down the Chinese ethnic group to explore differences in those migrants from, for instance, Mainland China or Taiwan. Only Lee et al. (2010a) have explored the Korean population in relation to health services use. To an extent this pattern of research attention may have been justified in the past considering the small population counts in many of the smaller Asian ethnic communities. However, with the increase in Asian ethnic group populations such arguments are no longer valid and concerted efforts to understand cultural barriers to health care are needed.

Much of the research on internal and international flows relating to people of New Zealand has been carried out by geographers. While the majority of this research has focused on documenting and understanding the main migration streams into and within the country (Bedford et al., 2002), in New Zealand migration research has also tended to centre on

Pacific migrant groups and the rural to urban migration of Māori (Bedford, 1987, Johnston et al., 2002, Bedford, 2009, Barcham et al., 2009). Attention has also been paid to the movement of New Zealanders to Australia (Green et al., 2008, Rose, 1957). More recently, there has been a movement to explore the Asian migration influx to New Zealand on an increasing scale which has examined Asian migrants' experiences since immigrating to this country (Bedford and Ho, 2008, Abbott et al., 1999). However, there remains space in the current research on the Asian migration experience in New Zealand, in particular research that explores those ethnic groups that become subsumed by the larger ethnic category and their health outcomes.

## **1.2 Migration and Health**

As well as affecting those who have moved, migrants themselves arriving in a place can have detrimental effects upon the people already living there. History is replete with accounts of Europeans arriving in a new place bringing with them new diseases that the inhabitants had no immunity to. In New Zealand this came in the form of influenza with mainly British settlers from the late eighteenth century to which Māori were much affected helping to reduce the population by half by the end of the next century (Crump et al., 2001). However, where once long sea journeys helped function as a barrier to the spread of communicable disease, containing the incubation periods of any such human infectious disease to the journey time, the advent of modern air travel has increased the risk of a potential epidemic. Even the longest transcontinental travel is now briefer than the incubation period of many diseases, producing thousands (if not more) of potentially infectious contacts on a daily basis (Frenk et al., 1997). Ongoing in recent times is the risk from pandemic influenza such as the H1N1 strain and newer strains of TB resistant to antibiotics (McCracken and Phillips, 2012). Conversely, people migrating into a new place

may also have their health affected by the new environmental conditions they find there as a result of being an ethnic minority.

In terms of the geographical research carried out on migration and health, there has been relatively little work conducted in the area of health and ethnicity. Much of the research on ethnicity and health has tended to be dominated by epidemiologists and has focused on disease prevalence in immigrant populations and ethnic differences in health status compared to a native population (Jackson and Evans, 2013). Gattrell and Elliot (2009) have highlighted the confounding nature of migration in health epidemiology, where disease occurrence is often accepted as being related to current place of residence. However, some long-term illnesses (e.g. heart disease or certain cancers) are developed over a long time, during which people may have moved several times confusing place influences on the disease. While epidemic studies can help inform our knowledge of health differences, they often fall short in terms of addressing the importance of *cultural factors* that can be central to the experiences of migration and health.

In addition to the international research, the health and migration research conducted in New Zealand has seen very little previous input from geographers. Conventional health and migration research in this country has largely tended to focus upon the health of Pacific Island migrant groups. For instance, there has been a substantial amount of work completed on the health of Tokelauan populations who migrated to New Zealand during the mid 1960s following a natural disaster in that country (Prior, 1975, Salmond et al., 1985). More recently, migration and health research involving Pacific people has included examinations of mental health disorders (Foliaki et al., 2006) and cancer trends (Tukuitonga et al., 1992). Nevertheless, despite the early emphasis on the changing health of Pacific people an increasing body of literature is beginning to emerge on the health of Asian migrants in New Zealand, particularly around mental health, (e.g. Abbott et al., 1999, Pernice et al., 2000, Ho,

2004, Rasanathan et al., 2006a) and this is reflective of the increased numbers of Asian people. Though further work is justified, health care directed at Asian migrants is also beginning to receive increased attention (See DeSuoza, 2005).

Over the years the New Zealand Health Survey have shown mixed results in terms of the association between the number of years lived in New Zealand and certain key lifestyle factors and health amongst the Asian population to determine if any were linked to an increased length of exposure to the New Zealand lifestyle. In the levels of sedentary activity a beneficial pattern was observed with the proportion categorised as sedentary decreasing with increasing time in New Zealand and the proportion of stipulated healthy eating (that includes eating 5 or more serves of fruit and vegetables per day) was highest in people born or resident in New Zealand for more than 10 years (48%) (Ministry of Health, 2006, Ministry of Health, 2012). However, levels of other adverse risk factors were reported to increase with the number of years lived in New Zealand that included a higher prevalence of alcohol consumption, levels of obesity and a decline in the proportion of never smokers. The Health Survey also found South Asian and Other Asian, along with Māori and Pacific women, were less likely to have had a mammogram in the previous two years; while women in all non-European ethnicities were less likely to have had a cervical smear in the previous three years, than New Zealand European women. While the Health Survey is useful in displaying trends in health care use, it does not explain the cultural reasons for that use, or the lack thereof.

### **1.3 Migration and Use of Health Services**

The high increase in migration globally in the past two to three decades has instigated a parallel increase in studies on population movements and health. While much of the work has focused on the health determinants and outcomes of migration, there has been less

attention to migrant utilisation of health care services. While research has been conducted in Europe, a considerable amount of this work has been carried out in North America. In the United States much effort has focused on Latino migrants and their access to health care (Nagi and Haavio-Mannila, 1980, Bermúdez-Parsai et al., 2012) with causes of low utilisation being lack of insurance, low income, language and visa status. In Europe a mixed pattern in utilisation has been found amongst studies looking at migrant access to health care. In a number of studies GP utilisation patterns amongst migrants have been found to be little different from the native-born within the countries under study (Spain, Germany, Italy and the United Kingdom), but at the same time, these studies have found migrants have lower access to specialists and are more likely to visit emergency rooms in the first instance than the native born (Antón and Muñoz De Bustillo, 2010, Wadsworth, 2013, Luca et al., 2013).

Research with Asian migrants has found differing patterns of health care utilisation between individual ethnicities. Frisbie et al. (2001) observed that Koreans were least likely to visit a physician or to have a regular source of health care. This occurred because of the cultural preferences of Koreans for traditional practitioners of “ethnomedicine” and because many lacked health insurance in comparison to Chinese and Japanese in the study. The histories of migration for these three ethnic groups in the United States differ. Japanese and Chinese have a longer record of residence in the United States than Koreans and this may influence health care utilisation through the influence of support systems. Thus, it may be that variation in the health care utilisation of minority groups, especially those comprising a large number of immigrants, can be fully understood only by taking into account additional factors, such as migration history and diversity of cultural norms and values, for which data suitable for inclusion in statistical analyses are frequently absent.

Despite low overall utilisation of health care by some Asian migrant groups, patterns of high enrolment, but low utilisation, have also featured within the research literature with



language barriers often being cited as a reason for low utilisation. In the United Kingdom Aung et al. (2010) found there was a high registration rate amongst a Burmese ethnic population, but a low rate of utilisation due to language. A number of studies have found English language proficiency to be associated with the number of times Asian migrants visiting a doctor (Akresh, 2009, Jang et al., 1998) and in the demand for ethnic concordant doctors (Leong et al., 2010). A greater likelihood of satisfaction and greater trust in Western medical care was also observed in individuals with better English-speaking ability.

Aside from language, barriers in accessing health care are multiple. Research has identified barriers for migrants which includes: being unclear about what services can be accessed, a lack of awareness of available services, affordability and cultural differences in assessment and treatment (Kim and Keefe, 2010). Lai and Chau (2007) found that barriers were related to administrative problems in delivery, cultural incompatibility, personal attitudes, and circumstantial challenges.

As with migrant health outcomes, the influence of cultural barriers to health service use change over time. Considerable emphasis has been placed on acculturation's role in migrant health outcomes, while much less work has been directed towards the influence of acculturation on health care utilisation, or the lack of. Much of the work on migrant utilisation of health care services and the effects acculturation has been carried out in Europe and North America (e.g. Glaesmer et al., 2011, McDonald and Kennedy, 2007, Van der Stuyft et al., 1989). Where researchers have looked at the influence of acculturation on health care utilisation, low patterns of use are typically found amongst recent arrivals, but with increasing utilisation, after a significant number of years. However, in a number of studies (Lee et al., 2006, McDonald and Kennedy, 2007) the acculturation proxy measure of residence time was found to not correlate with screening utilisation, speculating that the lack of utilisation is related to other variables of culture including age and beliefs in fate. In the

New Zealand context, to the writer's knowledge, no research has been carried out that has considered acculturation's role in influencing this form of health care utilisation, warranting greater research in this country.

Further, a dominance of quantitative methods used in health care utilisation on migrant population research has also created limitations to the depth of understanding into the drivers behind the uptake of health care by culturally diverse peoples. A reliance on, typically, surveys alone does not allow researchers to ascertain the effect health values and beliefs inherent to culture have on influencing health care utilisation and health outcomes, frequently leading to the use of speculation in these studies. Those studies which have employed a more qualitative methodology offer greater insight and depth into the influences of Asian ethnic minority utilisation of health care. For example, a recent Australian qualitative study on the lived experiences and acculturation to health care found that Asian migrants' cultural factors had a strong influence on their perceptions and ongoing utilisation of health care (Terry et al., 2011). This may be common across all cultures to some extent, but may not have otherwise appeared in a purely quantitative study. Cultural factors were also found in one of the few New Zealand qualitative studies on this area of interest, where it was suggested reasons for preferring an ethnic concordant doctor may be more related to cultural practices in health care use than simply to language difficulties (Lee et al., 2010a). The addition of qualitative approaches to research on migrant and health care utilisation thus has the potential to provide a more compelling answer to the perceptions Asian minorities hold in relation to health care in New Zealand.

Overall, the research on health care utilisation in geography has suffered by its tendency to neglect migration and culture as an influencing factor. In New Zealand this neglect is compounded by the near absence of a research focus on Asians. Where these people do appear it is in collated national surveys that have tended to group all sub-Asian

ethnicities as one. Given the high numbers of Asian migrants into New Zealand from disparate origins there is a clear need for research on Asian people that goes deeper than the single ethnic grouping. This thesis aims to add to the knowledge surrounding Asian migrants in New Zealand and the influences of cultural barriers on health care utilisation.

#### **1.4 Thesis Aims**

The overall aim of this research is to investigate how Asian migration into a new health system influences the perception and the utilisation of health care. Geographic perspectives necessitate the identification of the processes within Asian contextual inputs that influence health care inequalities of access. These processes may include socio-economic, displacement, health/wellbeing, contextual and cultural factors. With these points in mind the aim of this thesis will be achieved through answering the following research questions:

1. How have the health needs of the Asian population in New Zealand been met by the health sector?
2. How do 'home country' health experiences influence health care utilisation?
3. To what extent do modes of acculturation have in influencing utilisation of primary health care?
4. To what extent do perceptions and experiences of health care create barriers to utilisation of health care?

## **1.4 Thesis Structure**

This thesis is divided into 6 chapters. The present chapter has outlined where the current state of research into migrant health care lies, described the objectives of this research and the reasons as to why this research is important.

Chapter 2 outlines the research and provides a wider theoretical context of migrant health care utilisation and those aspects that can impact on the access to that care.

The third chapter provides a description of the local context of Asian migration to New Zealand. It examines the history and patterns of Asian migration, the social characteristics of migrants and their experiences after having arrived in New Zealand. The chapter also reviews the health outcomes of Asian people in this country.

Chapter 4 describes the methods used in this research, why they were chosen and the processes and challenges of working in a cross-cultural research project. The chapter also discusses ethical issues and the approval process required by the University of Canterbury Human Ethics Committee.

The fifth chapter explores the first research question. To do this the chapter begins with a focus on the patterns of health care utilisation by Asian people in New Zealand, situating this utilisation alongside other ethnic groups. The chapter then investigates and discusses the response of the health sector to the needs of Asians in New Zealand. This investigation includes the consideration of the views held with Primary Health Organisations (PHOs) and medical practitioners in Christchurch and Auckland with high Asian enrolment.

Chapter 6 explores the second three research questions. To meet this aim the chapter presents the analysis of the qualitative research with participants from three Asian ethnicities in Christchurch. It considers the patterns of their health care use prior to their arrival in New

Zealand and how this has changed since migrating. In addition the chapter examines the perception of the participants towards health care and the solutions sought when health care does not meet their needs.

Chapter 7 concludes this thesis by considering the findings of this research, discussing them in relation to the wider research literature and what the implications are for Asian people seeking appropriate health care.

## **Chapter 2 Conceptual Context**

### **2.1 Introduction**

This chapter provides the wider theoretical context of migrant health care utilisation in which the current thesis is sited and those aspects that can impact on migrant access to care. The chapter begins by describing the role place has had in health geography and how emphasis changed in the latter half of the Twentieth Century. This section is followed by an exploration of the role acculturation has in affecting the health outcomes and utilisation of health care by migrants. The chapter also reviews the work carried out on the barriers migrants face in accessing and utilising appropriate health care. This will be followed by an examination of how these barriers can affect a particular ethnic group.

### **2.2 Health geography and place**

Since the 1990s ‘place effects’ and their role in health outcomes have received increased attention on the part of geographers. Place effects are contextual or environmental factors that influence an individual’s vulnerability to physical or mental illness. They occur independently of individual attributes, such as age, sex or ethnicity, but are mediated by behaviours, health care access and social position that allow contexts to influence individual health outcomes. In addition, place effects can be derived from the everyday life experiences and memories of individuals and communities (Boyle and Willms, 1999). Place effects can operate at differing scales. These scales include the local neighbourhood effects on health and, at a wider scale, the role income inequality at a national level has in determining health outcomes (Macintyre et al., 2002, Auchincloss and Diez Roux, 2008). A sense of place describes how physical and mental health is associated with the bonds people have with places and with people in those places (Tuan, 1977). As Kearns (1993) has indicated, a sense of place gives insight into analyzing the health effects connected to experiences of place,

attachment or detachment to particular places, analysis that will be affected by the movements of people into and out of places.

Spatial variance in health gives credence to the idea place matters, that where a person lives will influence their health. However, as Graham et al. (2004) noted, due to differing methods in research, conflicting conclusions have been reached as to the role of place in having an influence on health. Kearns and Gesler (1998) have argued that emphasis on the quantitative methods within health research led to an invisibility of the “more nuanced geographies” of health and place that ethnographic and other qualitative methods can bring to research (p. 3). In addition, Kearns on a number of occasions has argued for medical geographers to search for new epistemologies (Kearns, 1993; Kearns and Joseph, 1993). Recently, in relation to place Acevedo-Garcia (2012, p. 1) has called for a refinement in the conceptualisation of context that is more specific to the “realities of migrants whose lives are embedded in multiple places”. An example of this mixed embeddedness is the retention of relationships across nationalities with family and others in their former communities via remittances.

Indeed, in relation to negative stereotypes of urban poverty, Keene and Padilla (2010, p. 1222) found how “spatial stigma” was embodied and transported to new destinations which worked to constrain the opportunities of those who had moved. Thus, as people move in and out of places they will carry that place with them, in terms of both its healthy aspects and unhealthy aspects. Migration and life-course have an influence on health; they are dynamic in that few people remain in the same place over their whole lifetime. Accordingly, having a health problem could well be as a result of a different environment complicating understandings of the current contextual effects on health and how they will seek care in the place the individual now resides.

From the early 1990s a resurgence in the interest role of place has in shaping people's health experiences occurred, with a new debate developing about the relative importance of either people or place characteristics (Macintyre et al., 2002). For example, Osypuk et al. (2010) have shown ethnic enclaves are a functional and protective place for a first generation migrant, but for second generation migrants these same places may be detrimental, having a possible strangling effect on social mobility. The characteristics of places have also been accepted as important determinants of migration (Walters, 2000), with these characteristics influencing the migration into or out of places. However, one of the problems of 'place effects' research continues to be the extent to which migration complicates things especially length of exposure to various environmental influences. Despite this few geographers have examined the relationship between migration and health care.

### **2.3 Geography and migration**

The study of population along with the movement of populations has been a part of geography for near as long as the discipline has existed. During the mid twentieth-century Robert Trewartha (1953) put forward that population provides the essential background for all geography. Population is "the pivotal element in geography, and the one around which all the others are oriented, and the one from which they all derive their meaning" (p. 97). While physical geographers may to an extent protest, this claim for population in geography may be true for human geographers. For without a population to study, there could be no human geography.

It is this movement of populations into and out of places and the reasons for doing so and the impacts of this movement that has interested geographers. Robinson (1996) has pointed that in the past the focus of geographers into migration has centred on firstly the identification of the fact that migration flows are taking place and then a focus on who was



involved in these flows; secondly, at a micro-level the study of an individual's reasons for migrating; and thirdly the impact of that migration. Accordingly, there was an early emphasis on macro-scale influences and the development of universal laws and hypotheses of migration (Halfacree and Boyle, 1993), as evident in the work of Ravenstein (1885) and Zelinsky (1971). However, the validity of Zelinsky's phases of migration hypothesis can now be questioned in certain regards. Physical distance has become less relevant in a more globalised world, having become greatly changed since his time in character and importance due to developments in transportation and communication. Ravenstein's 'laws of migration' are now outdated and attempting to create such laws is problematic as motivations for migration are not consistent, but are complex being related to economics and culture, amongst others, in particular places, both spatially and temporally. What's more, with the cultural turn in geography transnationalism, diaspora studies, and gendered approaches have more recently been utilised by geographers in this area of research and study (Blunt, 2007). The geographical research of migration has moved away from models of official statistics and aggregate data at a macro level (e.g. Zelinsky) to a more micro level using methods such as household surveys and life histories (Massey et al., 1998), which have helped broaden the theorisations of immigration (Graham, 2004). Cooke (2008) has called for a more centralised position for the role of family in discussions on migration, arguing that what is often seen as individual migration is in fact that of the family. An example of this is where a father choosing to move for improved employment opportunities will have follow on effects that act upon his family, whether they follow or stay behind.

Migration can be over small distances, such as within a city, or wider distances, to another town or city, and to a new country. The movement of people to new environments can have both positive and detrimental impacts on the health of those who move, those they join, and those they leave behind (McKay et al., 2003). Younger migrants, particularly those

moving longer distances, tend to be relatively healthy and thus, those places from where this age group have moved are likely to become characterised by a less healthy population, while the opposite will be true of a new destination (Bentham, 1988). Older people often migrate internally over short distances to move away from environmental health hazards or to be nearer health care, while still being near social connections.

Recently, Newbold (2012) argued that there has been a decrease in the research on migration in general, not only within geography, in part as a result of the increasing unavailability of data, particularly in the United States and Canada with the discontinuation of the census long form and the potential of such loss in the United Kingdom. As these censuses have been the mainstay of migration researchers, the future of migration research in general looks bleak without these invaluable data resources.

## **2.4 Migration and health**

An important question in migration research is the extent to which the movement of people from one place to another has both positive and detrimental effects on health (e.g. Hugo, 2007). For the most part, the geographical work on health and migration has been carried out by health geographers. The sub-disciplines of population geography and health geography share much common ground in terms of their subject matter (population mortality/morbidity and fertility) and the theoretical and methodological issues and debates in which they have engaged (Rosenberg, 1998). Since exposure and effect to illness are related to both time and place, Schaerstrom (1999) has argued geographical studies of ill health in modern society are complicated by high mobility, long periods of latency and environmental change causing a distortion between the cause and effect to be understood.

Much of the research on migration and health compares the patterns of migrant groups to the patterns of the host population. The health status of migrants is usually

different from that of non-migrants and this status can be influenced by both the country of origin and the destination, and by the very processes of migration. In addition, health can have an influence upon people's proclivity to migrate and where they migrate to (Bentham, 1988). After migration a migrant's health status may stay comparatively similar to those of their homeland, but it may also change, either appearing to be worse than in their home countries, to be better than in their home countries, or to have worsened or improved converging to the health levels of the new place of residence (McKay et al., 2003). The fact of moving can also negatively impact on an individual's mental health, particularly when moving to a new country, being a result of stress and depression derived from alienation in the new place and the need to grapple with a new cultural environment (Gatrell and Elliot, 2009, Mirdal, 2006). Further, the impact of this new environment can frequently have a gendered aspect, with isolation occurring for migrant women and in turn impacting on health outcomes. Aspects of the new physical environment may also impact upon a migrant's health. This can occur because of either human derived (e.g. air-pollution) or more climatic (e.g. humidity, temperature, solar radiation) (McKay et al., 2003).

**Table 2.1:** Some positive and negative effects of migration on health

Mostly Positive	Mostly Negative
<ul style="list-style-type: none"> <li>• Improved health at 'home' through remittances</li> <li>• Improved access to specialist health care</li> <li>• Short term mental health</li> <li>• Healthy migrant effect</li> </ul>	<ul style="list-style-type: none"> <li>• Mental illness</li> <li>• Obesity</li> <li>• Cancer</li> <li>• Diabetes</li> </ul>

### ***Mental illness***

Migrants face numerous sources of mental health, including job uncertainty, low income, social and geographic isolation, poor housing conditions, intergenerational conflicts

and separation from family. Much work has been carried out on migration and the mental health/illness outcomes of those who have moved and on the mental health issues encountered by immigrants in their new environments (e.g. Mirsky et al., 2007, Michel et al., 2012). Environmental factors in the new place of residence impacting on the psychological wellbeing of migrants, with higher psychological distress and psychiatric morbidity, were found to be very mixed between ethnic groups. However, Michel et al. (2012) also found social support to be a major stress-mitigating factor during migration. This mitigation of mental health risk through socio-cultural supports was also found by Anbesse et al. (2009) amongst Ethiopian female domestic migrants to Middle Eastern countries whose self-identified threats to their mental health included exploitative treatment, enforced cultural isolation, undermining of cultural identity and disappointment in not achieving expectations. A positive outcome of migration and mental health was found by Stillman et al. (2009) amongst Tongan migrants to New Zealand particularly for women and for migrants with lower levels of mental health to begin with. The authors suggested the overall welfare impact of migration is of benefit on short term changes in mental health status through improved health care, but this can erode over time.

### ***Obesity***

A leading health determinant, obesity has been of concern amongst health researchers for some time (e.g. Pawson and James, 1981). This interest has been due to the related illnesses which can lead on from increased and prolonged obesity such as diabetes and cardiovascular disease. Research suggests that the effects of migration on obesity levels are mixed. In Switzerland Volken and Ruesch (2012) found that the risk of overweight and obesity was higher amongst migrant groups (from Portugal, Turkey, Serbia, Kosovo and Italy) compared to Swiss nationals and suggested that this was due to the preservation of dietary practices by migrants in Switzerland and not related to length of stay. Similarly, in

Pawson and Janes's (1981) early study of Samoan migrants to Hawai'i there was a tendency for Samoans to become overweight, not only when they migrated and were exposed to "modernisation" in place, but also cultural beliefs and attitudes toward food and diet that may have been important in the cause of obesity in this migrant population. Duration of residence in a destination has also been found to increase the prevalence of obesity. In Canada McDonald and Kennedy (2005) found a low incidence of obesity amongst recent arrivals, but obesity increased with longer residence in Canada. However, the incidence of increased obesity was also related to ethnicity with South Asians showing the greatest rates of increase and Chinese showing the least. One reason for this difference in rates was the residence within large ethnic communities, such as is prevalent amongst the Chinese, decreasing the likeliness of weight gain. In rural-to-urban migration in India Ebrahim et al. (2010) found migration into urban areas was associated with increased levels of obesity by an adoption of urban modes of life, such as changes in diet and decreased physical activity. In addition, from a qualitative study with Iranian women migrants to Australia on the determinants of obesity Delavari et al. (2012) reported diet and physical activity affected by stress during the initial immigration transition were important factors.

### ***Cancer***

There has been much work done on the health effects of migration and cancer prevalence. Of note in this area of migration and health is the connection to population mixing. In places with high population mixing incidences of cancer prevalence have been found to be high and much work has been done on leukaemia in this area, particularly around childhood leukaemia (see the extensive work done by Kinlen). In addition, Miller (2008) found a higher incidence of childhood acute lymphoblastic leukaemia was observable in areas which increased the most in population mixing over short time periods of six to seven years. Pre-migration factors have also been found to have a role in a higher incidence

of cancer amongst migrants. Often these reflect not only the late access to health care and prevention programmes frequently encountered by migrants (Ziegler et al., 1993), but also correlations between socio-cultural level and place of origin (Barbone et al., 1996). In Sweden, a higher prevalence of cervical cancer was found by Azerkan et al. (2008) among older immigrants which was possibly due to the fact that they have had persistent human papilloma-virus infection or pre-cancerous lesions prior to migration. The authors suggest the lower probability of cancer screening might be an explanation for the increased prevalence, as women over 60 years of age are not invited to organised screening in Sweden.

### ***Diabetes***

An increase in diabetes prevalence has been found amongst increasingly urbanised populations. For instance, Misra and Ganda (2007) found the risk of the obesity and type 2 diabetes followed a gradient, as migrants became more affluent and urbanised, indicating the important role of environmental factors. Urban South Asian migrants, who are particularly predisposed to developing insulin resistance and type 2 diabetes, had prevalence rates four times higher than of rural populations. Contributing factors included nutritional change, physical inactivity, stress related to moving and an ethnic pre-disposition to diabetes.

### ***Workplace effects***

Migrants frequently find themselves in compromised working conditions exposing them to health risks and may not be in a position to complain, particularly if they are illegal. For instance, Ugalde (1997) has reported on research on agricultural labour migrants in Spain where these people showed high incidences of poisoning from pesticide exposure and risk from unsafe work environments. Bollini and Siem (1995) have shown that rates of work-related accidents are greater among migrants than local born.

### ***Left Behind***

Other work has examined the impact on health and welfare of those left behind after people have moved out. Thomas and Thomas (1999, p. 1082) have suggested a “rural ghetto” formed when poor African-Americans left farms in search of work. Migration to northern industrial cities in the United States, predominantly by skilled African-American men from the area of study, lowered the social capital of the community decreasing the ratio of men to women. This movement of people had the effect of increasing the likelihood of the contraction of disease within the community left behind. In contrast, the pattern of remittances has been seen to improve the health outcomes of those left behind (Ponce et al., 2011). With remittances, Lu (2013) found in Indonesia that adults in emigrant households were significantly less susceptible to suffer from forms of malnutrition, such as being underweight than those in non-migrant households and this improved nutritional status was restricted to people in households with labour migrants. This highlights the role remittances have in improving dietary intake. However, from a review of the literature, migration would appear to have a detrimental effect on health outcomes for those who have moved and for those left behind.

### ***Healthy Migrant Effect***

The healthy migrant effect posits that those people having more recently moved to a new country will be healthier than, or have a quality of health on par with, long term residents or the native population. The healthy migrant effect has been supported in a number of studies across a number of settings including intra-European migration and wider trans-national migration (Thomson et al., 2013, Hajat et al., 2010). A number of potential explanations have been postulated for this phenomenon which include: health screening of immigrants, self-selection of younger and more highly educated individuals among people considering migration, and under-reporting and under-diagnosis of health conditions

(McDonald and Kennedy, 2004, Ministry of Health, 2006). However, it is also posited that whatever health advantage recent migrants may have had will dissipate over time. The adoption of unhealthy behaviours, such as eating a high-fat diet, drinking, smoking, along with the wearing-away of cultural and religious values may contribute to the deterioration of health status among immigrants (Berry, 1997). A process of acculturation is an explanation for the good health often seen among newly arrived immigrant groups and the subsequent deterioration of the migrant health advantage over time.

## **2.5 Migration and Acculturation**

Originally a concept belonging to behavioural and social science anthropology, acculturation has been adopted by other disciplines including psychology, sociology and epidemiology (Salant and Lauderdale, 2003). Indeed, it was from anthropologists Redfield, Linton and Herskovitz (1936, p. 149) that the oft cited definition of acculturation as being “those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups”. Early on, acculturation anthropologists were interested in how so-called primitive societies changed to become more civilized, while sociologists have been concerned with how immigrants, through contact with a host population, gradually conformed to the ways of the host people. Acculturation is a process by which individuals or groups selectively accept and adopt aspects of another culture, often a more dominant one, without completely relinquishing their own. This process is not uni-directional with changes taking place in either or both groups. However, Berry (1997) has suggested that despite the neutrality in the two-way cross-cultural change that can take place, in practical terms, acculturation induces more change in one of the groups than in the other. Aspects of the



adopted culture may include beliefs, values, social norms and lifestyles (Parillo, 2008, Lopez-Class et al., 2011). Cultural contact can result in complete assimilation or the creation of a new composite culture combining aspects of the original and adopted cultures. As a concept, acculturation includes changes not only at the socio-cultural, but also at the individual level. Individuals and groups select parts of a dominant or contributing culture that fit their “original worldview” while striving to retain vestiges of their traditional culture. But, while some research work on acculturation has been carried out by geographers (e.g. Collie et al., 2010, Ward, 2009), research on acculturation has not traditionally been a part of geographic enquiry.

Within the research literature some confusion reigns over acculturation and assimilation and the definition of the two terms/processes. While a number of authors have discussed acculturation and assimilation and have called each a part of the other (Lee et al., 2013, Biddle et al., 2007), others have used the two terms interchangeably (including Kimbro et al., 2012) and the two terms have been classified as two distinct separate processes (Teske and Nelson, 1974). The authors argued the difference between the two is that acculturation requires some acceptance of the new culture, whereas assimilation does not, and unlike acculturation assimilation requires a favourable orientation with the new culture. It has also been argued that along with integration (bringing of people of different ethnicities into unrestricted and equal association), separation and marginalization, assimilation is a strategy towards a level of acculturation. Within this notion of strategy, assimilation is one in which an individual comes to adhere to a new culture leaving behind their culture of origin.

Approaches to the measurements of acculturation and the extent to which a migrant has come to accept or adopt a new place of residence have included simple proxy measures such the length of time an immigrant has been in the new country and level of language

ability with the host culture. However, linear measurement of time has been critiqued as being uni-directional and frequently ignoring bi-culturalism (Salant and Lauderdale, 2003). Language, though often a means of adapting to a new culture, has been found in a number of studies to not always be a predictor of use of health care (McPhee et al., 1997, Ying, 1992). Other than language, some of these proxy measures-including generational status (e.g. first, second, or third generation), age at immigration, place of birth make an assumption that acculturation can be estimated by the amount of exposure individuals have to the dominant culture. More multi-dimensional measurement methods exist such as the Suinn-Lew Self-Identity Acculturation Scale<sup>1</sup> (SL-SIAS) which sums up to 26 items measuring acculturation and ethnic self-identification; low, medium, and high scores of acculturation are termed “Asian-identified,” “bicultural,” and “Western identified,” respectively (Suinn et al., 1992). This scale has been adapted in a number of studies to fit the ethnic group under consideration with some success.

While the process of acculturation is complex, it is often also a function of age, cultural heritage and language, and circumstances that individuals or groups face in the new social environment in which they find themselves (Marin, 1992). Acculturation is, in consequence, a process of place; for migrants the links that exist between the old and the new home will each play a role in influencing health outcomes and determinants. There are connections and attachments that bind people to place, and this is more so in cities with their more cohesive ethnic populations which allows for cultural norms in healthcare to persevere (Cresswell, 2004, Stafford et al., 2010), and these in turn will influence how health is accessed. But it should also be noted that both negative and positive outcomes may result from acculturation (e.g. loss of valued cultural characteristic). However, as Berry (1997) has

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<sup>1</sup> Suinn-Lew Self-Identity Acculturation Scale was developed specifically for Asians. The scale includes variables of language, food, cultural interest and patriotism.

noted the costs to an individual by not adopting an acculturation policy are likely to be even greater, particularly if segregation and marginalisation are the result.

Segregation of minorities could also lead to decreased integration into the dominant culture. Deborah Phillips (1981) writing on the social and spatial segregation of the Asian population (predominantly those of South Asian/Indian ethnicity) in Leicester, England, suggested residential dispersal did not indicate a shift in the attitudes of the migrant population towards the indigenous population, in this example a white English one. Cultural assimilation or acculturation could not always be equated with a move away from segregation in cultural communities, but could only be seen as a realisation of their own aspirations in regards to housing and, despite some inter-cultural contact, the migrants remained culturally isolated. Philips points out that this dispersal for many of the migrant population under study could at best be seen as one step towards partial integration and not as a “precursor to full assimilation” or acculturation.

### ***2.5.1 Acculturation and health determinants***

There is a substantial body of literature on the degree to which those moving to another country adopt the health profiles and ill-health risks of the people who have always lived there. However, debate remains on the veracity of the phenomenon with many studies supporting the acculturation hypothesis (Vella et al., 2011, Smith et al., 2011) while others do not (Harding and Balarajan, 1996). Acculturation into a western social system has frequently been shown to have a detrimental effect on health determinants and the commensurate health outcomes (Ministry of Health, 2006). This consequence demonstrates the influences of place to be a strong contributor to health determinants. The ways in which migrant health patterns alter with variation in acculturation is of increasing interest to

researchers, but little is known about the mechanisms that may link acculturation and self-rated health, particularly for Asians.

Recent studies have found conflicting results on the role acculturation has to play in influencing changes in health determinants. For example, employing the National Latino and Asian American Study and its data on foreign-born Latinos and Asians, Kimbro et al. (2012) explored the associations between acculturation and self-rated health for immigrants to the United States from the six major ethnic subgroups. The authors suggest that migrants who maintain their native language while also attaining English proficiency realize a bicultural fluency, which is in turn reflective of better health. Using wide ranging measures of acculturation, the authors (ibid.) demonstrated that across ethnic groups the dominance of native-language in daily use was linked with worsening self-rated health compared to greater bilingualism, and measures of lower acculturation are linked to better self-rated health. Additionally, these associations were only moderately mediated by socioeconomic status and not mediated by acculturative stress, discrimination, social support, or health behaviors. Conversely, Riosmena and Dennis (2012), using data from the Mexican Family Life Survey and the United States National Health Interview Survey, examined whether immigrants imported their health gradients from the source country, or whether these gradients change as a result of SES-graded acculturation. With respect to two health indicators, obesity and current smoking, the researchers found confirmation that the gradients of migrants measured prior to coming to the United States were not statistically different from those of non-migrants, as the gradients of each were comparatively weak. Although the gradients for obesity and smoking appear to weaken with time spent in the United States, the differences were not significant, suggesting little support for the selective acculturation hypothesis.

On smoking prevalence alone, the uptake of smoking due to level of acculturation can be related to gender and age. With gender, a small study comparing Korean-Americans

and ‘native’- Koreans found that, as acculturation progressed, there was a preference towards things American and a shift in lifestyle practices away from the Korean (Song et al., 2004). Interestingly, there was a reported mix to changes in smoking prevalence; men were less likely to smoke with increased acculturation, but the reverse was shown for women (perhaps because of the high stigma towards women smoking in Asia and more social freedoms in the United States). In addition, an American study on Asian migrants indicated that acculturation had a variable effect on smoking behaviour (Ma et al., 2004). There was a higher prevalence of smoking among more acculturated youth while less acculturated male adults had higher rates than more acculturated male adults. Further, smoking rates for all females were generally lower than those of males regardless of acculturation status. However, acculturated adult females had a higher smoking rate than the less acculturated. Thus, acculturation can have a mixed to positive outcome for particular components of migrant populations in relation to smoking.

Acculturation has also been found to have a role in increasing risk to obesity and thus leading to further ill-health. A UK study comparing a number of migrant groups with a “white reference” group suggests in only the second generation from migration ethnic minority groups converged towards obesity irrespective of age or sex, with education and class level being a factor in this outcome (Smith et al., 2011). A positive progression towards alignment with the base-‘white’ population increased with time as acculturation advanced. Further, a study on a sample of young Mexican and Mexican-American women, found women who scored high on an acculturation scale had higher BMI, body fat, fasting insulin, diastolic blood pressure and were more likely to have two features of metabolic-syndrome than women who scored low on the scale (Vella et al., 2011).

Related to obesity and nutritional health, a number of studies have found the Western preoccupation on body-image to be detrimental to migrant self-esteem, representing a

differing slant to acculturation's influence on migrant health outcomes (Mussap, 2009, Cachelin et al., 2006). In Australia there was found to be a positive relationship between "thin ideal internalization" in Muslim-women and the thin ideal commonly held in western-cultural Australia (Mussap, 2009), while in the United States body dissatisfaction and eating disorders occurred amongst second generation Mexican-American women (Cachelin et al., 2006). Such findings indicate that there is an additional element of gender to migrant health outcomes and to an extent highlights a requirement for tailoring health interventions towards identified at-risk migrant women's needs. Acculturation processes in health outcomes can frequently be seen as a dichotomy in that while acculturation tends towards a favouring of a host dominant culture, the perception of health determinants such as obesity and smoking may be related to culture and can flow in either direction towards increased health inequalities.

### ***2.5.2 Acculturation and healthcare utilisation***

To date most of the work on acculturation and health has focused on migration and health outcomes and less on use, or lack of use, of health services. Differences in health outcomes and utilization of health services are not necessarily related to length of stay equating acculturation. Length of stay in a host country and acculturation are not one in the same; the first does not lead into the other (Boyle and Norman, 2010). A Belgian study on the influence of acculturation<sup>2</sup>, urban-rural provenance and length of stay on service utilisation characteristics of primary health provision found acculturation appeared to be a strong determinant of migrants' utilisation of primary healthcare, whereas simple length of stay only marginally leads to a conformity with host culture attitudes (Van der Stuyft et al., 1989). The authors point to the perceptions derived from these experiences could be both

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<sup>2</sup> The study used an index of acculturation based on styles of dressing and level of local language knowledge.

negative and positive and may well be related to the level of healthcare received in their country of origin in contrast to that of the new country of residence.

Migrants can also carry their health care practices with them to their new country of residence, continuing to utilise these forms of care. A United Kingdom study on perception held by migrants towards health care found there was a tendency for Chinese women to retain and pursue a dualistic approach to health care remedies despite the length of migration (Green et al., 2006). Further, in the study it was found that Chinese women were reluctant to have mental health issues described in a Western framework, maintaining their own cultural approaches to mental health. This reflected the perceived stigma attached to mental health problems. While perhaps something not only retained by a Chinese population, this attitude does link place for migrants in turn influencing the level to which they will acculturate to a new health care system. There is the possibility of migrants having multiple experiences of healthcare both prior to migration and in their adopted country and since one will influence the other such considerations need to be included in any discussion on health policy toward migrants. The pace at which an individual acculturates to a new system of health provision will lower the barriers towards the access to and utilisation of that system.

## **2.6 Barriers to healthcare utilisation**

Access to health care is not always equal. Barriers to the ability to access health services may include distance, travel time to services, transport (including mode of transport, road conditions and patient mobility), socio-economic barriers (income, insurance), language and ethnicity, health literacy, and health status.

Penchansky and Thomas (1981, p. 128) in defining access to health services as the “degree of fit” to health care describe a five point schema of the domains of access that includes availability, accessibility, accommodation, affordability and acceptability (Table

2.2). Through this schema the authors view access as a broad concept that summarises a set of specific dimensions that influence the ability and desire of potential patients to use the health care system. In other words, the compatibility between the characteristics of the health services and health provider on one side and the characteristics and expectations of patient in the other will each influence access to care. The authors suggest where any problems arise with any aspect of this schema they are likely to influence a client and the health care system in three ways: utilisation of services will be lower, as will client satisfaction with the services they receive, and practice patterns of the provider may be affected due to lower utilisation by the client. With ‘availability’ a wide-ranging selection or supply of services and personnel that are known to the patient to the meet patient’s needs will be in existence. ‘Accommodation’ refers to such aspects as opening hours, consultation booking systems and the patient’s ability to accommodate and adapt to the services available.

**Table 2.2:** Penchansky and Thomas’s (1981) five dimensions of access schema.

<b>Dimension of access</b>	<b>Definition</b>
<b>Availability</b>	The relationship between existing services and the client’s needs.
<b>Accessibility</b>	The relationship between supply location and client location.
<b>Accommodation</b>	The relationship between organisation of supply to accept clients and ability of the client to accommodate to the services.
<b>Affordability</b>	The relationship of costs of services to the client’s ability to pay, whether through income or insurance.
<b>Acceptability</b>	The relationship of clients’ attitude about the characteristics of providers and vice versa.



While access barriers such as distance and the connected travel time to services, and issues of transport fall into the accessibility dimension and the socio-economic barriers (income, insurance) are a part of the affordability dimension, the cultural barriers to health care (language and communication, ethnic/cultural practices and beliefs and health literacy) fall into the acceptability and, to lesser extent, accommodation dimensions of access. Acceptability is from the migrant's recognising the services provided are suitable culturally and the accommodation and availability dimensions are the health service's ability to provide services to match the migrant's needs.

However, Joseph and Phillips (1981) reduced accessibility to health services to two key types: physical and socio-economic. Physical refers to a service's existence and the means to reach it, while socio-economic is peoples' ability to pay for care. Humphreys and Smith (2009) describe the most basic measure of this accessibility concept as being a result of the spatial or geographical separation of healthcare consumers, the demand side, from the healthcare facilities, the supply side of the equation. Thus, measures of accessibility help to quantify the relationship between obstacles that arise from location of services and the ability of users to overcome them.

The barriers to health care utilisation have long been a subject of interest for health geographers, frequently as a factor of accessibility (Table 2.3). Much of this research interest has focused on the barriers to accessing primary health care due to distance from health provision and patient mobility (e.g. Arcury et al., 2005, Gesler et al., 2006, Panelli et al., 2006, Nemet and Bailey, 2000, Joseph and Phillips, 1984, Hiscock et al., 2008), while others have explored socio-economic barriers to care (e.g. Wilson and Rosenberg, 2002, Law et al., 2004, Barnett, 2001, Brown & Barnett, 2004). The accessibility to healthcare refers to the level individuals and communities are readily/easily able to obtain health services.

Geographers have also to a limited extent explored factors of culture as creating barriers towards utilisation of health care at any level (e.g. Gellert et al., 1995, Lee et al., 2010a).

**Table 2.3:** Overview of work by geographers on barriers to health care utilisation.

Author	Country	Barrier variable
Bentham & Haynes (1985)	UK	Distance, Mobility
Haynes (1991)	USA	Transport
Senior et al. (1993)	UK	Multivariate
Gellert et al. (1995)	USA	Cultural
Nemet & Bailey (2000)	USA	Distance, 'Co-locality'
Barnett (2001)	New Zealand	Socio-economic status
Wilson & Rosenberg (2002)	Canada	Distance, Economic
Gesler (2004)	USA	Rurality, Distance
Law et al. (2004)	Canada	Economic
Arcury et al. (2005)	USA	Transport
Panelli et al. (2006)	New Zealand	Policy
Wellstood et al. (2006)	Canada	Health system barriers
Woltamn & Newbold (2007)	Canada	Multivariate
Hiscock et al. (2008)	New Zealand	Distance
Haynes et al. (2008)	New Zealand	Deprivation
Loh et al. (2009)	USA	Distance, Capacity
Lee (2010a)	New Zealand	Cultural
Comber et al. (2011)	UK	Distance, multi-variate
Harrington et al. (2012)	USA	Distance

Affordability as a barrier to accessing health care services is influenced by many factors, naturally including an ability to overcome the cost barriers to that care. Cost barriers can include a lack of health insurance (Rivers and Patino, 2006) and a general inability to self-finance (Ludeke et al., 2012). In the United States a lack of health insurance has resulted in lower utilisation of health care particularly among minority ethnic groups, the poor and the newly arrived (Ryu et al., 2001, Sohn and Harada, 2004, Choi, 2006, Derose et al., 2007).

Distance from a health provider as a barrier to accessing health care has been much discussed in the research literature (Joseph and Phillips, 1984, Bentham and Haynes, 1985, and others). The distance concept of accessibility of appropriate healthcare is the relationship

between the location of supply and the location of the user. With increased distance from a GP surgery/clinic there was a reduction of elective acute inpatient visits (Haynes et al., 1999). For those with disability various requirements for access to clinics/medical centres are frequently compounded through distance barriers (Kirschner et al., 2007). Meade and Emch (2010) have pointed out, examining accessibility is not simply a matter of measuring the distance travelled by a patient from their home to a clinic, but is also one of time constraints. Also, as Leung and Takeuchi (2011) have posited the simple presence of a nearby neighbourhood clinic does not automatically equate to accessibility. Health care access and utilisation increases when trust, in the form of outreach, collaborative partnership and cultural and linguistically capable services is built between community and health care providers, and accordingly, of acceptability.

Cultural factors have also been identified as a barrier in accessing health care, being a factor of service acceptability. Issues around the cultural alignment can include differences between the health provider and patients' perceptions, attitudes, and beliefs (Table 2.4). Cultural barriers can sit across the availability and acceptability dimensions of accessibility to health service. Issues with cultural fit identified in research have included perceptions of being patronised, being treated without respect and previous experiences of bias and differences in perceptions of illness and death. Cultural barriers to accessing care can be summarized as including language barriers, cultural barriers related to modesty, and gender preferences in seeking and accepting health care from male or female providers (Kulwicki et al., 2000). In addition, providers and patients may misinterpret each others' behaviours compounding the feelings of discomfort in each. In a Canadian study Johnson et al. (2004) found three forms of "othering" in respondent's descriptions of their problematic health care encounters included essentialising, culturalising and racializing attitudes towards migrant women, which in turn, led to worsened health care provision and to these women being seen

as problem patients. In recent years, cultural competency training amongst providers has become a common means to overcoming such issues (Habersack et al., 2011).

**Table 2.4:** Aspects of cultural barriers towards health care utilisation

<b>Cultural Barrier</b>	<b>Description</b>
Values and beliefs	Values and beliefs involve systems of health beliefs which explain what causes illness, how it can be treated, and who should be involved in the process.
Stereotyping	A process essentialising behaviours, values, and beliefs in ways that ignore individuality and diversity by providers.
Stigma	A fear of deviating from a social norm of a wider group, aspects of health not discussed publically, particularly around sexual and mental health.
Communication	Communication barriers stem from language and health literacy.
Experience	Past experiences with health care may influence how an individual responds to a new system of health care provision.

In addition to culture, and as a factor within, communication has long been identified as a barrier in accessing health care either initially or effectively. Effective communication in health care is essential to ensure patient safety, accurate diagnosis and health promotion (Johnson, 2004). The role of communication as a barrier to health care access ranges from how and which language is used through to whether printed health information is suited to a patient's age, gender, culture, and literacy level. Most frequently, problems in accessing healthcare have been linked to troubles with language and these have become better

understood (Terraza-Núñez et al., 2011, Butow et al., 2011, De Maesschalck et al., 2011, Saldov, 1991).

Communication barriers through language can be much associated with cultural barriers, as how language is used can vary between differing cultures and to how the patient will relate to the provider. Too frequently family members have been required to perform translation services (Green et al., 2006, Holmes, 2012, Elliot and Gillie, 1998), circumstances that have been described as highly inappropriate on moral and ethical grounds. In addition, Flores (2006) has reported that in hospital settings in the United States numerous inappropriate people were frequently to be found providing improvised interpreter services to those with low levels of language ability. These interpreters may include family members, friends, and even strangers found in waiting rooms. They are also unlikely to have an adequate understanding of the medical terminology and are more prone to making errors that lead to adverse clinical consequences.

The ability to access health care can be determined by an ability to comprehend the healthcare system of the adopted nation or culture that a lack communicative ability can exacerbate. Differences can apply to places unrealised by new health providers and without suitable guidance migrants may find themselves lost within an unfamiliar system, unable to access care in a timely manner. Communication barriers have frequently been found for migrant groups in their ability to access health care.

Within the research literature the language barrier has been of particular concern for migrant groups. An Australian study on the experiences of 10 Asian women in Tasmania found language to be one of the key issues in accessing healthcare and that there were greater issues through language barriers than cultural beliefs (Hoang et al., 2009). Further, in another Australian study on the four largest resident ethnic groups in Melbourne it was found the Vietnamese were more likely to have issues with language and a desire for an ethnically

matched medical practitioner over the Italian, Greek and Anglo-Saxon populations (Leong et al., 2010). However, there are very likely Asian ethnic or cultural factors in language acquisition that may also come into influencing this finding. Surprisingly, Hadziabdic et al (2009) found the use of an interpreter as a barrier, despite there being a necessity for communication with healthcare staff and as a guide through the healthcare system. This barrier was associated with when interpreters were spoken to directly by the health provider and not as an aid in personal interaction with the interpreter simply as an aid to communication. In the United Kingdom Aung et al. (2010) found that there was a high registration rate amongst a Burmese ethnic population, but a low rate of utilisation, language barriers were one of the reasons most frequently reported for this low utilisation of health care services and the rationale for self-medicating with non-prescription pharmacy bought medication. Additionally, with some members of a migrant community there is also the possibility of a limited level of literacy in the minority's own native language (Gopalkrishnan, 2004). This would further limit the extent to which understanding of health systems can be obtained and any ability to access health care services. Amongst a Vietnamese cohort in an Australian study there was a higher preference for ethnic concordant doctors, with this being more a result of language requirements (Leong et al., 2010).

Strongly connected to language and communication barriers to health care access for migrants are cultural barriers. Cultural barriers have been particularly problematic for Asian and Muslim migrants into Western contexts. Religion and cultural background influence individuals' beliefs, behaviors, and attitudes toward health and illness. Some barriers, such as modesty, gender preference in healthcare providers, and misconceptions around the causes of illness, arise out of their cultural beliefs and practices. Amongst Arab Muslim migrants in the United States Odeh-Yosef (2008) found modesty, gender preference in health care

provider, stemming from their religious and cultural background, hindered their access to health care despite an increased risk for diabetes and CDV. For Asians, culture barriers featured in influencing the level of utilisation of health care. For instance, in the United States Frisbie et al. (2001) reported visits to health a provider were uncommon across all Asian ethnicities, though low health outcomes were prevalent for all Asian ethnicities apart from Japanese. Moreover, cultural attitudes towards mental illness, such as stigma, create barriers towards the use of services (Dow, 2011).

Barriers to health care utilisation are multifold and can be deepened and harder to overcome for migrant groups with the availability, accessibility, accommodation, affordability and acceptability all coming into play. Seeking solutions to culturally suitable health care can often cause an individual to seek care elsewhere.

### ***2.6.1 Travel for access to health care***

To overcome these barriers to accessing timely and appropriate health care many have sought health care far removed from their regular local providers. Short-term migration has to some extent provided a means to respond to barriers for those unable to find appropriate health care where they live. Health tourism has of late become a significant component of global health care provision.

The relationship between tourism and health is not new. Travel to ‘take the waters’ was carried out by the Romans, and spa towns and mineral springs have long since promoted themselves on the healthiness and recuperative effects of taking the waters (Connell, 2011a). Therapeutic landscapes have been seen to facilitate an acceptance of health tourism sites as curative spaces which combine modern and alternative forms of medicine with travel and leisure (Buzinde and Yarnal, 2012, Kearns and Collins, 2000, Horowitz and Rosensweig, 2007). There have been some issues as to what specifies health tourism as all tourism may

constitute activities that promote health and wellbeing to some extent (Hall, 2013). This may point to where there is a difference between health and medical tourism. Medical tourism has been defined as the international phenomenon of individuals traveling to access health-care services that are otherwise not available due to high financial costs, lengthy waiting lists or limited health care at home (Johnston et al., 2010, Hall, 2013). However, Connell (2011) has questioned whether medical tourism, if medical care is the primary intention of travel, can be construed as tourism at all when there can be little pleasure involved. Hall (2013) argues sooner than using the common interpretation of tourism as being travel simply being for leisure or pleasure, a more refined definition of tourism that includes all short-term travel for medical and health related purposes. Much of the research on medical tourism has been conducted by disciplines other than geography.

However, medical tourism generally describes a pattern of movement of people, particularly those from more affluent to less affluent countries, for medical care (Wilson, 2011, Johnston et al., 2010). This has been described as a possible change from previous instances where those with higher SES in developing countries travelled to developed countries to access improved medical care (Snyder and Crooks, 2012). Whatever the definition of medical tourism, the reasons for traveling to access health care are numerous. Impediments to accessing medical care in the country of origin are frequently cited as being the leading motivation for traveling to another country, these being financial (e.g. lack of insurance or too higher cost), overly long waiting times for elective surgery and/or the procedure being unavailable in the country of residence (Gan, 2013, Connell, 2011b). Connell (2006) has posited those with no or limited insurance are left with little choice but to seek medical care outside of their own country due to the high costs of treatment at home, or long waiting lists on public health systems such as in the United Kingdom.



As an alternative to the typical model of travellers leaving their own country of origin to receive medical care in another foreign land, Lee, et al. (2010a) have pointed to Koreans resident in New Zealand opting to return to their native country to access medical care. The authors give reasons for returning home as stemming from issues with language during consultation, lack of cultural awareness and distrust of the New Zealand health system, particularly the use of General Practitioners. In addition, a German study found for students in the Netherlands distance partly influenced whether students travelled to home in Germany, returned home or stayed in Maastricht, and the type of care accessed with the key motivations being familiarity with home providers and system, and reimbursement issues of costs incurred (Glinos et al., 2012). The limited scale of research into this phenomenon of returning home for health care and treatment provides much scope for further research.

## **2.7 Conclusion**

This chapter has explored the theoretical setting of the factors influencing migrant access to, and utilisation of, health care providing grounding for this thesis into the Asian utilisation of health care in Christchurch, New Zealand. Both migration and health have long been of interest to geographers. Migration can be both detrimental and beneficial to health outcomes for those moving to a new country either short or long term. Migrants may be healthy before they make the move, but an adoption of the norms within the new country of residence can decrease that health, while the reverse is also true for those with poorer health upon arrival. Although the latter is less prevalent, due to the health screening requirements of many receiving countries within their immigration regulations. Further, studies featuring multiple ethnicities find high heterogeneity can exist between each culture, frequently limiting the number of generalisations about the Asian population as a whole (Yu et al., 2010, Jang et al., 1998). This final point demonstrates the need to focus on the differing ethnicities

in health research. The barriers to accessing appropriate health care are intertwined, not being easily separable from each other. Migration exacerbates these barriers, raising further hurdles that need overcoming. While language has been much discussed in the research literature, cultural attitudes and beliefs towards health and health care also need to be overcome or accommodated for migrants to successfully access health care in their new country of residence.

## **Chapter 3 Asian migration into New Zealand**

### **3.1 Introduction**

This chapter explores the context of Asian migration into New Zealand, the history of this migration and the experiences and outcomes of Asians living in this country. These aims will assist in placing Asian migrants into the New Zealand context and how this context has affected Asian health and health care utilisation.

To meet these aims, the chapter is divided into two sections. The first part explores Asian migration trends into New Zealand, examining where Asian migrants are coming from and in what numbers. The remainder of the chapter will describe the experiences Asians have encountered in living in New Zealand. These include the social outcomes of the migrants (e.g. socio-economic status and employment) along with the health outcomes of migration and residence in New Zealand. Many of these issues are interlinked and are not completely separable from each other.

New Zealand's population history has always been one of migration. The first peoples to arrive in New Zealand, Māori, did so as migrants and following the 1840 Treaty of Waitangi large numbers of Europeans flowed into the country in ever increasing numbers. While small numbers of Chinese could be found in New Zealand at this time, immigration tended to be discriminatory towards favouring European migration into the country (Ip, 2002, Ballantyne and Moloughney, 2006). This situation remained until the mid-1980s when immigration policy changed away from a bias on Europeans. Despite the long history of Chinese and Indian settlement in New Zealand, the greater part of overseas-born people who identify with an Asian ethnicity have been in this country for a relatively short time. Thus, Asian migrants to New Zealand have had a varied experience in this country, with this variance being dependent on ethnic origin, purpose of migration and socio-economic status upon arrival.

### 3.2 Who is Asian?

The term 'Asian' is a broadly defining term. It is thus important to note how problematic essentialising the term 'Asian' is and when this term is used as an ethnic category this broad definition becomes particularly acute. As used in New Zealand, the category 'Asian' is a varied combination of diverse peoples, placing together a very dissimilar range of ethnic and cultural populations, each of which has a different place of origin, language, culture, traditions, settlement history and health needs. Placing this diversity into a single 'Asian' category conceals the separate ethnic identities that exist between them, averages out their differences and disguises the important distinctions (Rasanathan et al., 2006b). In addition, the *Longitudinal Immigration Survey: New Zealand* (Statistics New Zealand, 2010a) has further broken down the Asian category into North Asia, South Asia and South-East Asia. Within the North-Asia sub-region are included Japan, Korea and the various Chinese derived nationalities such as China, Taiwan and Hong Kong.

Including more than half the population of the world under a single Asian ethnic or cultural term has no more meaning or accuracy than classifying all the rest as non-Asian. In addition, the term Asian does not have a single fixed, uncontested meaning; it has dissimilar meanings in different contexts. As Raitz (1979) has pointed out 'ethnicity' does not describe the differences that may be present among people living within their own national borders and thus it would be inappropriate to use the word ethnicity to identify Japanese or Koreans living in their own countries. Ethnicity is therefore the result of social interaction between people of different culture groups and the realisation by both the host population and the minority group that there is a difference between the two groups in culture and behavior (Raitz, 1979).

The Asian category, and those people who fall within it, as used in New Zealand official statistics and in research, has been used since 1996 by Statistics New Zealand in its measurement of ethnicity and analysis of census results (Statistics New Zealand, 2010c). This definition includes people with origins in the Asian continent from Afghanistan in the west to Japan in the east and from China in the north to Indonesia in the south. Thus, this definition includes those who identify as Chinese, Indian and other peoples from East, South and Southeast Asia, excluding those people from Middle Eastern and Central Asian countries (Table 3.1). All those falling within this geographical area are categorised Level 1 ethnic level for statistical purposes. Level 2 divides Asian ethnicities into regional categories based on size of the populations in New Zealand, but South East Asian is typically subsumed into Other Asian. Of importance to this thesis is the Level 3, the most detailed level. The Level 3 ethnicity level generally separates population into nationally based ethnicities. It may be noted that this method of Asian categorisation is one peculiar to New Zealand, differing to how 'Asian' is defined in other countries. For example, until the 2011 census for England and Wales in the United Kingdom Asian was defined as someone from the 'sub-Continent'- India, Pakistan and Bangladesh. The United Nations description of regions includes the Arabian Peninsula within Asia.

**Table 3.1:** Asian ethnic category Levels 1, 2 and 3 as defined by Statistics New Zealand

<b>Ethnic level</b>					
<b>Level 1</b>	Asian				
<b>Level 2</b>	Other Asian	Indian	Chinese	South East Asian	Asian NFD <sup>a</sup>
<b>Level 3</b>	Japanese	Indian NFD	Chinese NFD	Southeast Asian NFD	Asian NFD
	Korean	Bengali	Hong Kong Chinese	Filipino	
	Afghani	Fijian	Cambodian	Cambodian	
	Sri Lankan NFD	Indian Gujarati	Chinese Malaysian Chinese	Vietnamese	
	Sri Lankan Tamil	Tamil	Singaporean Chinese	Burmese	
	Sri Lankan NEC <sup>b</sup>	Punjabi	Vietnamese Chinese	Indonesian	
	Sinhalese	Sikh	Taiwanese	Laotian	
	Bangladeshi	Anglo Indian	Chinese NEC	Malay	
	Nepalese	Indian NEC		Thai	
	Pakistani			Southeast Asian NEC	
	Tibetan			Other SE Asian	
	Eurasian				
	Asian NEC				

<sup>a</sup> NFD = No Further Definition, <sup>b</sup> NEC= No Ethnic Category

It is also important to note that being born in an Asian country does not necessarily equate to being of an Asian ethnicity. As Bedford and Ho (2008) have noted, having an Asian ethnicity such as Chinese or Indian does not automatically mean that one originates from China or India. An ethnically Chinese individual could originate from Malaysia, or an Indian from Fiji. Consequently, it requires recognition that Asian peoples who are resident in New Zealand can come from many different places or indeed may be born in this country.

### 3.3 Asian Migration trends

Despite having a long history of Asian migration, albeit on a relatively small scale until recently (Ward and Masgoret, 2008), the majority of the New Zealand population has

traditionally been received through immigration from Europe and more exclusively Great Britain (Castles and Miller, 2009). Early immigration policies were designed to hinder Asian migration to New Zealand. These policies included the £10 poll-tax on all Chinese migrants under the Chinese Immigrants Restriction Act of 1881 that was not repealed until as late as 1944 and the right to citizenship was not permitted until 1952. These policies were essentially a function of a less honest policy environment in New Zealand than the upfront ‘White-Australia Policy’ maintained in the latter country. These policies were accompanied by a wider anti-Asian rhetoric warning of the ‘Yellow Peril’ (Lai, 1974). In the mid 20th century some sectors of New Zealand society, particularly church organisations and to a lesser extent employers, became critical of the New Zealand Government’s apparent timidity towards immigration reform.

The scale of Asian migration to New Zealand changed following a fundamental transformation in New Zealand’s immigration policy from 1986. At that time liberalised immigration policies were liberalized with the aim of attracting immigrants with professional skills, irrespective of race and country of origin (Ho et al., 1997), resulting in a boom in the numbers of Asians migrating to this country. Some of this can be attributed to successive New Zealand governments having introduced policy initiatives looking to revitalise flows of investment capital from Asia which has been attended by an active promotion or encouragement of migrants from countries from this region of the world (Bedford et al., 2002). This later point has encouraged parents to migrate to New Zealand to be with children and grandchildren.

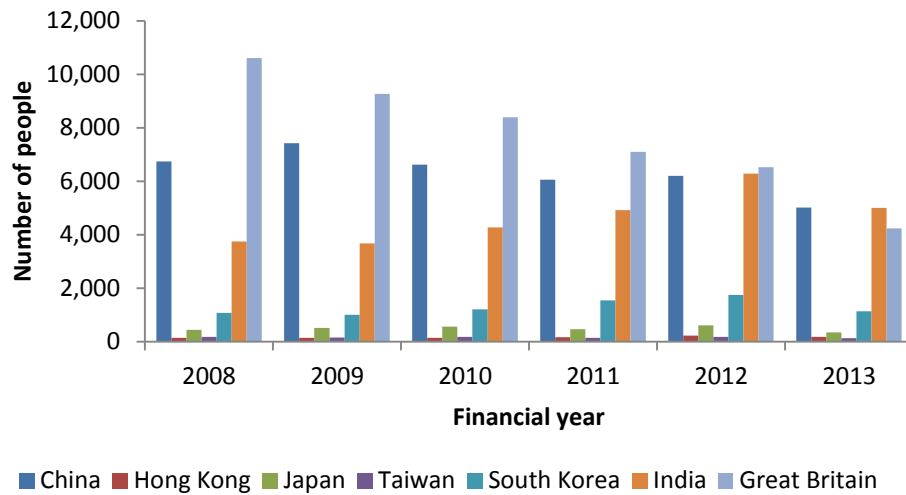
Immigration policies during the mid 1980s were commensurate with a change in the perception of Asians held by policy makers (from one of poor and populous to one of ‘rich tigers’), but was something not always shared by the general population in New Zealand (Beal and Sos, 1999). There has also been a perception that Asian migrants use New Zealand

as a stepping stone to Australia where immigration requirements are slightly stricter, particularly around language (Lidgard, 1996).

### ***3.3.1 Spatio-Temporal Trends in Asian Migration***

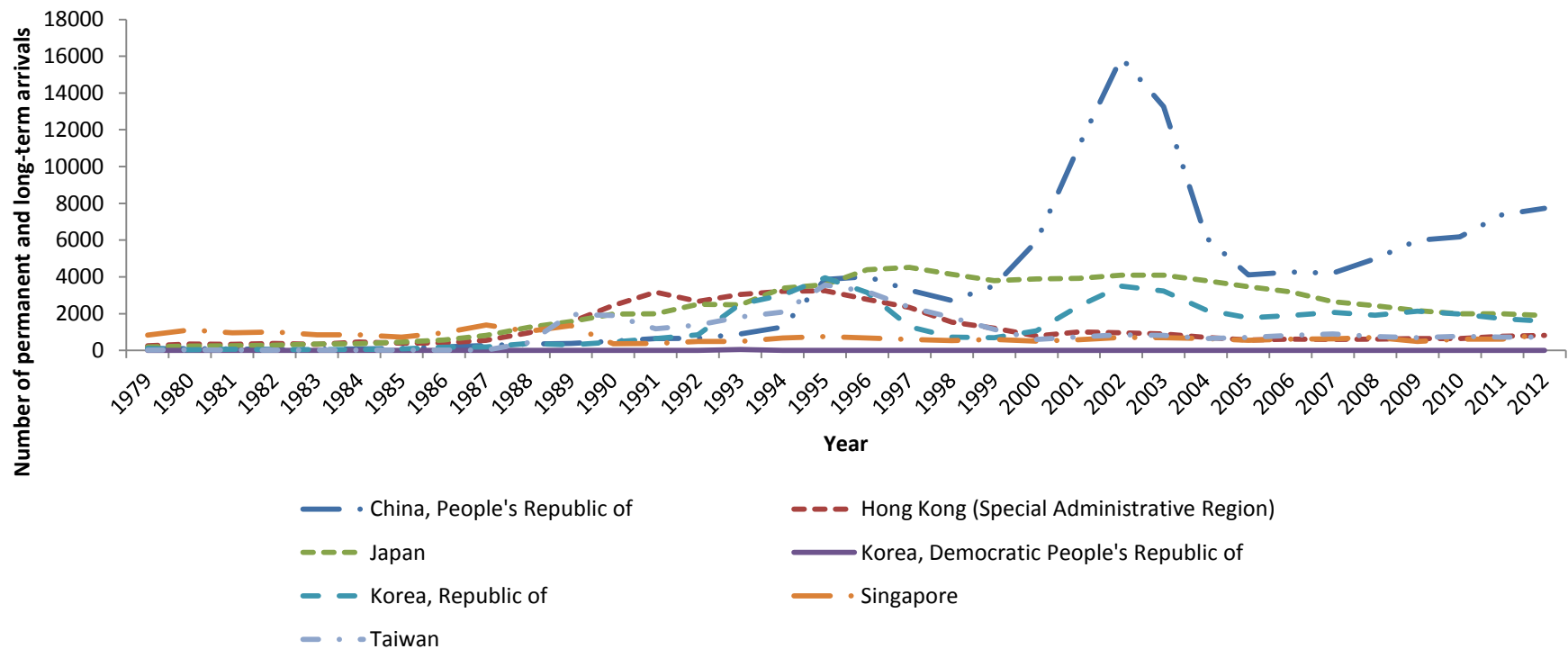
Those people who identify with an Asian ethnicity or ethnic origin compose one of the fastest growing sectors of the New Zealand population. In the 1991 census Asian people made up 3% of the total population, but by 2021 this proportion is projected to increase to 14.5%. Prior to the 1986 policy change the largest Asian sub-group moving to New Zealand were Vietnamese and Cambodian refugees and during the 1970s and 80s the largest Asian sub-group receiving Permanent or Long-Term visas were from India, Sri Lanka, Malaysia and Singapore (Bedford et al., 2000). In 1987 a new immigration act was passed which moved to a selection process based on personal characteristics such as educational qualifications, rather than a system that favoured particular source countries (Treasury, 2009). This act opened the way for increased immigration from Asian countries, although Great Britain remained, as it does still, an important source of migrants to New Zealand (Figure 3.1)





**Figure 3.1** Number of people included on residence applications decided, by nationality and financial year end 31 March. (Data source: Immigration New Zealand).

The number of ethnic-Chinese (PRC, Hong Kong, Taiwan and Singapore), Japanese and Korean permanent and long-term arrivals into New Zealand from 1979 to 2012 are shown in Figure 3.2. Here can clearly be seen the low rate of North Asian immigration into New Zealand up until 1986, followed by a much more mixed, but increased, rate of inward migration. The higher rates of migrants originally from Hong Kong are reflective of the uncertainty in the lead up to the return of the territory to China in 1997. Once the return of the territory had occurred, the flow of migrants from Hong Kong settled to a lower rate than in previous years, whereas the flow out of mainland China grew peaking at 16,000 migrants in 2002. This is likely a result of changes to the freedoms around internal and outward migration policy in China beginning in the late 1990s post-Tiananmen Square.



**Figure 3.2** The number of ethnic-Chinese (PRC, Hong Kong, Taiwan and Singapore), Japanese and Korean permanent and long-term arrivals into New Zealand from 1979 to 2012 (Data source: Statistics New Zealand).

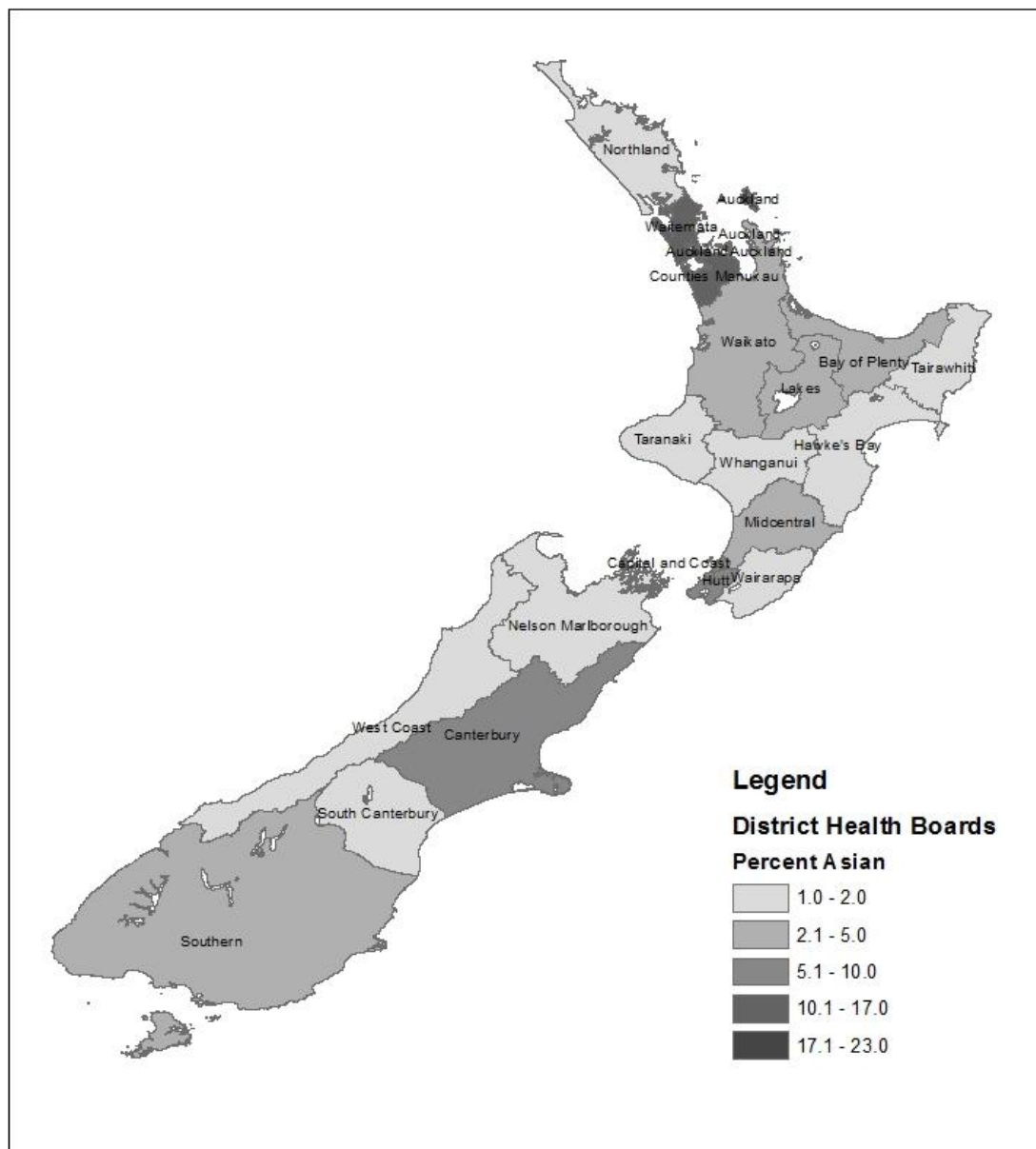
Of the six top source countries for residence approvals in 2011/12 the highest was the United Kingdom (15%), followed by China and India (13% each), the Philippines (8%), and Fiji and South Africa (6% each). At present, the top source countries of approvals in the skilled migrant category (SMC) remains the United Kingdom along with India (17% each), followed by the Philippines (13%), China (8%) and South Africa and Fiji (7% each). In 2011/12, India passed the United Kingdom as the top source country for SMC principal applicants (2,145 approvals, 23%). The number of SMC principal applicants from India increased by 27% from 2010/11. Reflecting a long-term trend, the increase of applicants from India is primarily due to former Indian international students who transition to temporary work and then on to permanent residency status (Statistics New Zealand, 2013).

In 2006 the Asian population represented 8.3% of the total New Zealand population and was the fastest growing population grouping between 1996 and 2006 (Table 3.2<sup>3</sup>). increasing from 173,502 in 2001 to reach 354,552 in 2006. This represented a 204% increase over the 10 year period, but down from the 403% increase for the previous 10 year period, which is likely a result of the change in immigration laws in 1986.

**Table 3.2:** Percentage of ethnicity and percentage of change as total of New Zealand population over 10 year periods 1976-2006.

	<i>European</i>	<i>Māori</i>	<i>Pacific Peoples</i>	<i>Asian</i>
<b>1976</b>	88.13	8.84	2.01	0.79
<b>1986</b>	83.34	12.26	2.98	1.35
<b>1996</b>	75.89	13.79	5.33	4.57
<b>2006</b>	61.24	13.27	6.24	8.32
<b>1976-1986</b>	98.45	144.5	154.28	178.35
<b>1986-1996</b>	108.59	134.13	213.65	403.43
<b>1996-2006</b>	90.64	108.02	131.52	204.35

<sup>3</sup> Due to differing methods of asking and recording ethnicity between each census, some figures will not be completely accurate. For example, in 1976 only Chinese and Indian were separately distinguished thus enabling inclusion in an Asian population count, while any other Asian ethnicity was included in 'Other' making for a lower overall Asian population figure.



**Figure 3.3** Distribution of Asians in New Zealand by District Health Board.

Most Asian immigrants have tended to settle in the greater Auckland region (Figure 3.3). Canterbury, Waikato and Capital and Coast District Health Board (DHB) regions have high concentrations of Asians, all regions with large urban environments in contrast to more rural regions which have smaller Asian populations.

Currently, the Asian population is the fourth largest ethnic grouping in New Zealand, but this ranking is expected to change in the next decade. Statistics New Zealand estimates that the Asian population is projected to nearly double to 789,000 in the period between 2006

and 2026 (Table 3.3), a rate of increase significantly greater than the three other major ethnic groups. The Asian population is the only ethnic group projected to have substantial net migration gain over the 20 year period.

**Table 3.3** Projected population change, of major ethnic groups, 2006-2026 (series 6)

<i>Ethnic Group</i>	<i>2006 (000)</i>	<i>2026 (000)</i>	<i>Number (000)</i> <i>2006-2026</i>	<i>% increase</i>
Māori	624	807	183	29
Asian	404	789	385	95
Pacific	302	479	178	59
Other	3,213	3,444	231	7

(Source: Statistics New Zealand Population Projections)

The seven largest Asian populations in New Zealand, as shown in Table 3.4, have seen an increase in the number of residents between 2001 and 2006. Of the seven largest Asian populations, the Indian population is the fastest increasing followed by the Korean population. While the Chinese population remains the largest Asian group, the rate of increase has been much less.

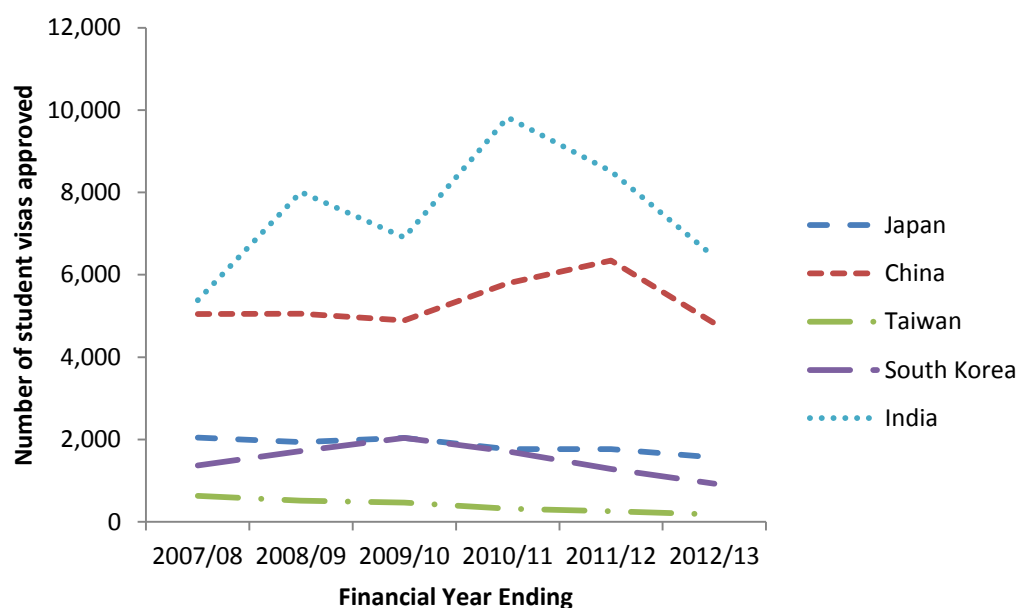
**Table 3.4:** Seven Largest Asian Ethnic Groups with change in size between the 2001 and 2006 Censuses (the 2013 census was as yet unavailable at completion of thesis)

<i>Ethnic Group</i>	<i>2001 count</i>	<i>2006 count</i>	<i>2013 Count</i>	<i>Percentage change</i> <i>2001-2006</i>
Chinese	105,057	147,570		40.5
Indian	62,190	104,583		68.2
Korean	19,026	30,792		61.8
Filipino	11,091	16,792		52.7
Japanese	10,023	11,910		18.8
Sri Lankan	7,011	8,310		18.5
Cambodian	5,268	6,918		31.3

(Source: Statistics New Zealand).

### ***3.3.2 Short or long term migration?***

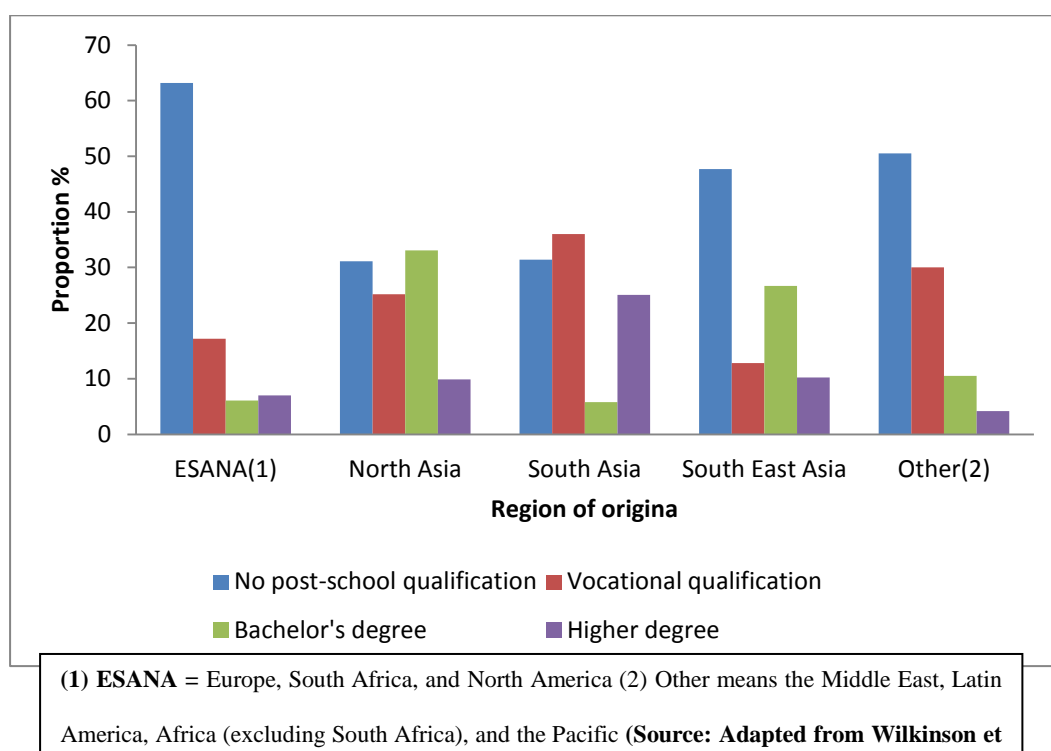
The length of stay in New Zealand differs for many people and can create fluctuation in the recorded resident population in New Zealand. Long-term generally means those who intend to remain in New Zealand for 12 months or more. Reasons for migrants being in New Zealand short-term include being on a Working Holiday Visa, Work Visa, or for education. Education is an important export commodity for New Zealand and students enroll at all levels of education in New Zealand from primary through to tertiary. Asian countries are the primary source of international students into New Zealand. China is the single largest source country for international students into New Zealand representing 25% of all such students in 2011/12. China as a source country is followed by India 13% and South Korea 10% (Plumridge, et al., 2012). An additional feature of those in New Zealand to attend primary school is that they may have a parent who also migrates to New Zealand on a temporary basis in order to take care of their child. This temporary migration could be for less than a year, for the period of the school year, or could extend over a number of years, but would feature a return home between school years. Thus, the Asian population would fluctuate throughout any given time period, possibly to the point of following the school year.



**Figure 3.4** People included on student applications decided, by nationality and financial year of decision (Source: Immigration New Zealand).

The number of international students in New Zealand is important as many students frequently transition to residency after having completed their studies. This process may be directly from study to residency or through first transitioning to work in New Zealand and then on to residency. During the period 1997 to 2006 23% of international students made the move from student status to working visas. Such a working visa status is typically taken by those who have completed a tertiary level qualification and allows a former student one year to then find permanent employment that utilises their qualification. As can be seen in Figure 3.3 a high proportion of international students are not completing post-school qualifications and this is going to affect whether their ability to meet the requirements for a work visa are met and also likely reflects that many of these students are children. What is important here is the number of North Asian students who complete a bachelor's degree increasing their opportunities for work in New Zealand after they graduate, however realized those

opportunities may be, influencing their decision to settle more permanently in New Zealand than merely staying for the period of their study.



**Figure 3.5** Highest qualification gained in New Zealand by region of origin.

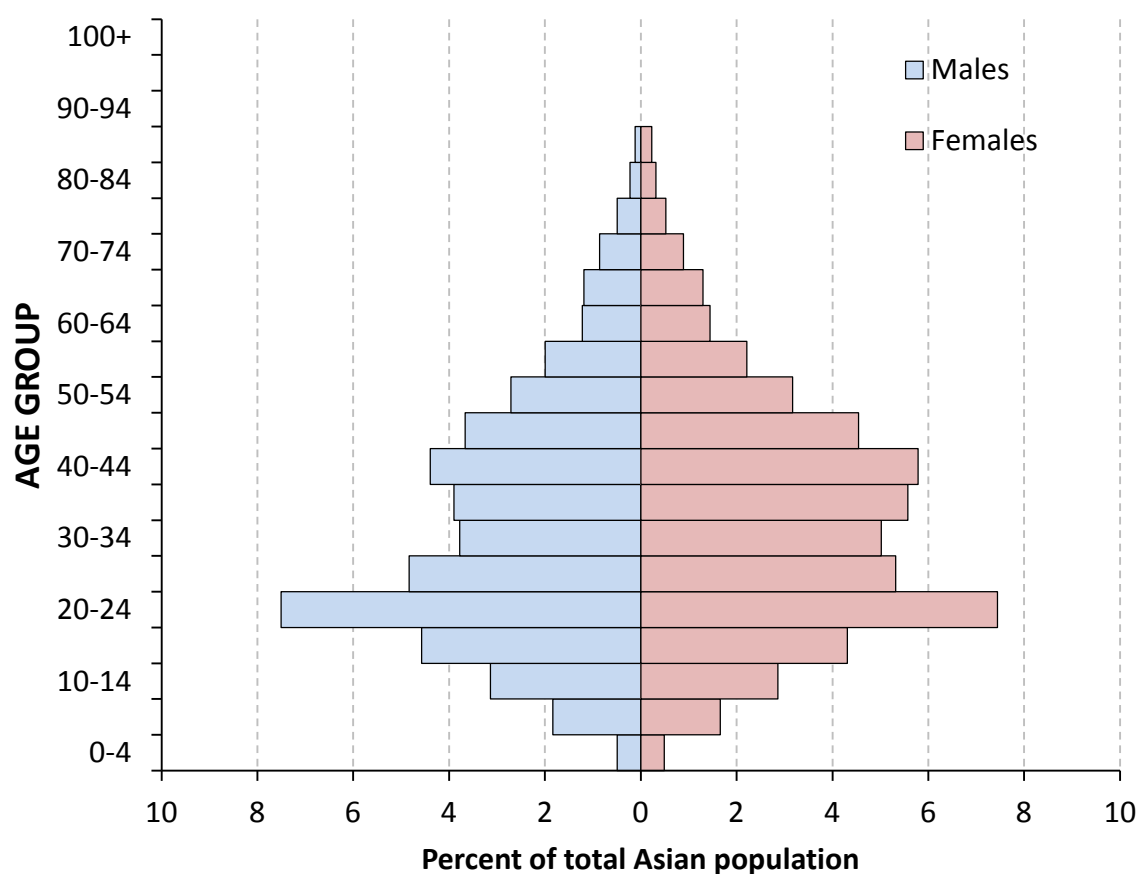
Additionally, the advent of the working holiday scheme allows young people, aged 18 to 30 years, to remain and work in New Zealand for up to 12 months. The nature of the working holiday visa only permits employment in a single job for a length of three months as an individual coming to New Zealand on the visa must come firstly to holiday, with work or study being secondary intentions for the visit. This restriction would cause a certain amount of internal migration of within New Zealand and without success in finding employment may force working-holiday visa holders to return home early. However, not being eligible for social services (non-residence status) in New Zealand these visa holders are likely to poses travel insurance, including for medical care.



### ***3.3.3 Demographic and Social Characteristics***

With over 80% of the Asian population and 91% of the Asian workforce having been born overseas, discussion of the nature this population becomes one of a discussion of migrants. The age of the Asian population in the workforce is young. In the 2006 Census half of the Asian working-age population was between 15 and 34 years of age, higher than the national average of just over a third. The youthfulness of the Asian working-age population can be ascribed to three factors: the presence of international students in New Zealand, particularly from China and Korea; the children of Asian immigrants who migrated to New Zealand in the middle of the 1980s, who were aged in their early 20s in 2006; and many migrants being young, due to the age selective criteria in immigration policy.

For a considerable proportion of the history of Asian migration to New Zealand the gendered structure of the Asian population was predominantly a male one. This gender structure was much a result of Chinese males migrating to New Zealand in search of work, particularly in the gold-fields of Otago and Westland (Ip, 1990). As is depicted in Figure 3.6 the modern gender structure of the Asian population in New Zealand is one which favours females. This is much more apparent in the ages over 25 years and particularly for Japanese. This female biased ratio across all Asian ethnicities may be explained by intermarriages, longer life expectancy for females and the existence of astronaut families, the latter being a phenomenon amongst the three ethnicities considered in this thesis.



**Figure 3.6** Population pyramid of the Asian population in New Zealand in 2006. (Source: 2006 Census).

**Table 3.5:** Asian ethnic groups by gender (Source: 2006 census<sup>1</sup>).

	<i>Total Asian</i> <sup>2</sup>		<i>Chinese</i>		<i>Korean</i>		<i>Japanese</i>	
	Male	Female	Male	Female	Male	Female	Male	Female
Total NZ by Territorial Authority	169,374	185,175	70,773	76,794	14,490	16,302	4,407	7,500
Males/100 Females	91.5		93.5		88.9		58.8	

1. Population levels from the 2013 New Zealand Census had not been released at the time of thesis completion.

2. Includes all Asian ethnicities e.g. Indian.

As with the New Zealand born population, the socio-economic status of migrants can be very mixed. The current objective of New Zealand's immigration policy is to contribute to economic growth through enhancing the overall level of human ability in New Zealand,

encouraging enterprise and innovation, and fostering international links, while maintaining a high level of social cohesion. With these objectives in mind, permanent residence in New Zealand is currently granted on a basis of eligibility under three residence streams: skilled/business, family and humanitarian/international (refugee or regional quotas). As opposed to Pacific Peoples who are more likely to gain residence through the Pacific quotas or family streams, Asian migrants to New Zealand are more likely to gain residence through the skilled or business stream and to a lesser extent by the family stream (Statistics New Zealand, 2013).

Economic conditions on arrival have a strong bearing on migrants' labour market outcomes. Those migrants arriving under the business category in particular, with its monetary requirements<sup>4</sup>, are more likely to experience having a higher socio-economic status. Moreover, those arriving under the family stream can be expected to have high socio-economic status due to the education, skills and health requirements of immigration to New Zealand. However, these expectations have not always played out in reality after migration.

### **3.4 Experiences of living in New Zealand**

The experiences of migrants to New Zealand may not always have been consistent with their expectations. When moving to New Zealand migrants have faced issues of assimilation or multiculturalism and key problems faced by living in New Zealand such as discrimination, employment and income equality.

#### ***3.4.1 Assimilation or multiculturalism?***

For those people who migrated to New Zealand with their parents the level of assimilation and integration can be very mixed. Termed the 1.5 generation (and typically

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<sup>4</sup> The Investor Plus category requires a minimum investment of NZ\$10 million for at least three years, while the Investor category requires a minimum investment of NZ \$1.5 million for at least four years.

counted as being under 12 years of age at the time of migration), these people may be more disinclined to remain in New Zealand upon reaching adult age. As these young migrants are highly motivated to seek higher educational qualifications and more highly-skilled careers, being at a minimum bi-lingual, and having to some degree transnational experience are just as likely to seek their careers in places other than New Zealand (Bartley and Spoonley, 2008).

To some extent the Asian population has trended towards increased segregation. Using the New Zealand Census data from 1991 to 2006, Grbic et al (2010) concluded that levels of residential segregation from the majority European population have been increasing gradually for Asians. Moreover, people who identified as Asian reported the highest levels of racial discrimination in any situation and after being a recent migrant had been controlled for, those people who identified as being Asian were more likely to feel lonely (Statistics New Zealand, 2012b). There were differences across age groups with these effects of segregation, with the association only being significant for young adults. The likelihood of young Asian people feeling lonely was twice that of those young people who did not identify as Asian (Statistics New Zealand, 2013). This effect of cultural identification upon loneliness is possibly from an ability, or lack thereof, to connect and assimilate with mainstream New Zealand culture.

However, the common assumption of Asian concentration in particular Auckland neighbourhoods has been challenged by Friesen (2008), who demonstrated that of the distribution of those born in China, India and Korea were widely dispersed over the city. While there were concentrations of people born in these three countries, the analysis showed the spread of their distribution is much greater than frequently assumed. This distribution reveals a willingness for at least the three groups in the study to live in neighbourhoods that are ethnically mixed, a signifier of assimilation.

For New Zealanders perhaps one of the biggest markers of community assimilation is the involvement in sport. Until recently there have been few Asians involved in mainstream sport at a prominent level. While professional rugby has seen the recruitment of Japanese players into the national sport and Indian players in the Black Caps, there has been little showing in other teams at the national level. And the recent celebrity of Lydia Ko, a migrant from South Korea, as a New Zealand golfer has brought Asian sports people to the forefront of national attention. However, a multicultural mode is maintained in sport by such organisations as the New Zealand Indian Sports Association and a tendency to participate in sports more familiar, such as Japanese to playing baseball, that country's *de facto* national sport<sup>5</sup>. Evidence is suggestive that involvement in sports clubs has assisted Asians to become more accepted into the 'Pakeha' community as being more engaged and less segregated in New Zealand life (Watson, 2007). As Ip has suggested, when discussing Chinese women in New Zealand, they are "no longer estranged" and have become "increasingly confident to interact" with the dominant population in a more positive way (1990 p. 15).

The modern communication environment has also enabled migrants to maintain cultural links with their birth-counties. The ability to watch recent television broadcasts keeps adult migrants and their 1.5 generation and/or New Zealand born children immersed in culturally relevant language content that helps reinforce cultural norms. Frequently among those migrants who have taken up New Zealand citizenship identification with New Zealand over the birth-country can remain "rather weak" (Ip, 2012). Even among the respondents who have taken up New Zealand citizenship, identification with New Zealand is rather weak compared to identification with the country of origin. Over 50 percent of the respondents identified themselves with the country of origin, although a significant minority (23 percent)

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<sup>5</sup> *Sumo* is the official national sport of Japan, but has a much smaller following than baseball, being more accessible.

claimed a hybrid identity, saying that they were both a New Zealander and Chinese/Taiwanese/Hong Kong.

The three Asian ethnicities (Japanese, Korean and Chinese) participating in this thesis have had varying experiences in their histories of migration and living in New Zealand. While there are many similarities to the problems faced with living in New Zealand, there remain differences from the cultural, economic and political backgrounds of the migrants. The ability of the Asian migrants to assimilate successfully into New Zealand society has had a mixed outcome.

Participation in political and civic affairs is a marker of assimilation into society. Active political and civic participation can be a precursor to representation on, for example, school boards of trustees, or in local or national government. Voting in elections is also an important indication of social participation and thus assimilation. In politics at the national level a number of Asian migrants have achieved election to the New Zealand Parliament and have done so as members across the political spectrum, such as Raymond Huo (Labour Party) and Jian Jang and Melissa Lee (both National Party members) (New Zealand Parliament, 2013); the first two being first generation migrants from China and the latter from Korea.

Barriers remain for Asians in the integration and assimilation into New Zealand society and perhaps the major barrier is one of language ability. For New Zealand this is one of an ability to speak English. North Asians have been found to self-rate their English ability as being lower and more likely to report no improvement over time (Plumridge et al., 2012). Further, North Asian migrants have poorer English than other migrants. This self-reported lack of ability is irrespective of whether the migrant has studied or gained a New Zealand qualification and is perhaps reflective of confidence in speaking and communicating in another language not one's first language and not an issue with actual ability. The level of language ability is reflected in the hourly rate of income of former students who have

transitioned from a student visa to a residency visa with those having a moderate to poor level of English receiving lower hourly income rates than those with high English proficiency (Wilkinson et al., 2010).

### ***3.4.2 Key problems faced with living in New Zealand***

All migrants will experience some problems moving to a new country including ones of discrimination, employment, housing and social isolation for Asians moving to New Zealand. Many of these issues are interlinked and are not completely separable from each other.

#### ***Discrimination***

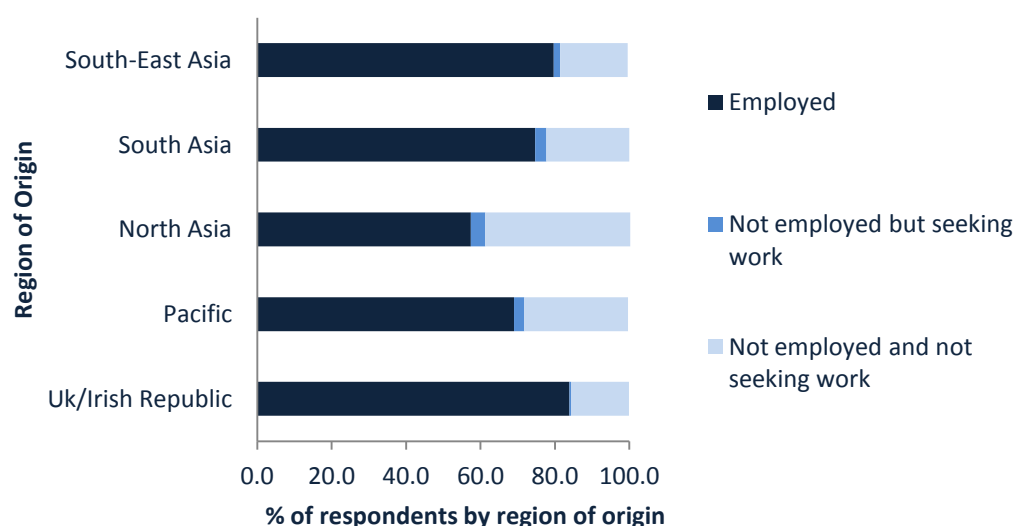
Racial discrimination in any setting was most frequently cited by Asians followed by Māori and Pacific peoples (Statistics New Zealand, 2012b). The most frequently cited reason for feeling discrimination was skin colour, race, ethnicity or nationality. After public places such as the street, the workplace is the place most frequently reported as being where people received the most discrimination (Statistics New Zealand, 2010a). Butcher et al. (2006) concluded much of the discrimination towards Asians is around employment and in gaining employment. This discrimination can frequently come during the pre-employment period by the non-recognition of overseas qualifications and experience.

In the New Zealand Health Surveys of 2002/03 and 2002/06 there was an increase in the reporting of ever having experienced racial discrimination of 28.1% and 35.0% between the two reports respectively among Asian peoples. However, this remained largely unchanged for other ethnic groupings (Māori 29.5%, Pacific 23.0%, European 13.5%). Touching on health Harris et al. (2012) have concluded that racial discrimination experienced across an array of settings has the potential to impact on a wide range of health outcomes and risk factors. However, most Asian migrants find most New Zealanders to be friendly and

problems may be as a result of a lack of cross-cultural awareness, or the lack there of (Butcher et al., 2006).

### ***Employment and Income***

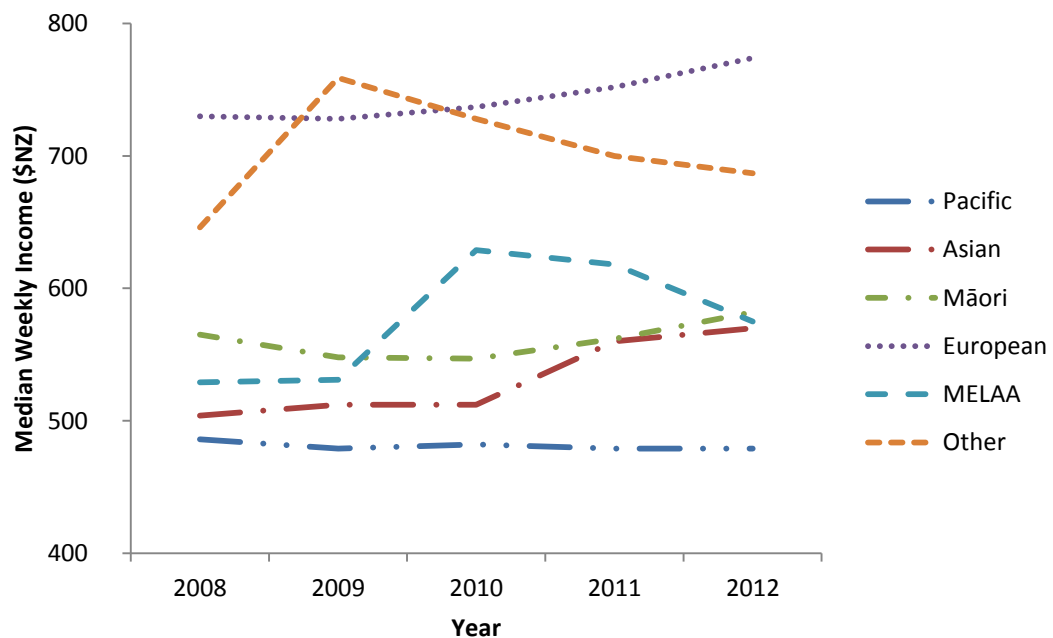
Finding employment in New Zealand is a particular problem for the Asian population as a whole. In the Longitudinal Migration Survey migrants from North Asia are less likely than migrants from the UK/Irish Republic to participate in the labour market (Figure 3.7). Those migrants of North Asian origin who are not in the labour market are more likely than migrants from many other groups to be studying or caring for dependants a common reason for being in New Zealand, the latter especially for many older North Asian migrants. This may be related to difficulties in finding employment, which in turn may influence a decision to undertake other activities such as study.



**Figure 3.7** Migrants labour force status by region of origin at wave 3 of the Longitudinal Migration Survey (Data Source: Longitudinal Migration Survey Data, Statistics New Zealand).



Yet, Asians are among the lowest income earners of the migrant groups upon arrival in New Zealand and tend to remain so after a number of years living in the country (Statistics New Zealand, 2012a). As is shown in Figure 3.8, the median weekly income from all sources for Asians is the second lowest of all the ethnic groups in front of Pacific Peoples, but behind those in the MELAA<sup>6</sup> ethnic group. Over the five years shown<sup>7</sup> income has displayed a continued increase.



**Figure 3.8** Median weekly income for all people aged 15 years and over, by ethnic group, 2008-2012. The data for income by ethnicity to the level presented is only available from 2008 (Source: Statistics New Zealand).

However, despite being among the lowest paid in New Zealand, the positives of moving to New Zealand can also be found amongst Asian migrants. Migrants from Asian countries were most likely to report increases in income on migrating to New Zealand, but while these New Zealand incomes may be lower than those of other skilled migrants they

<sup>6</sup> The MELAA group includes those people of Middle Eastern Latin American and African origin.

<sup>7</sup> Data including the Asian group separated from 'Other' was not available prior to 2008.

were a substantial increase from incomes in the migrant's region of origin. An example of this is amongst nurses from the Philippines and India who report increased earnings, as well as better general working conditions in New Zealand (Masgoret et al., 2012).

However, issues remain for migrants in the workplace, with these problems also having a gendered aspect. Kim (2004) found in the accountancy profession, ethnic minority women in general, but Chinese women in particular, were situated at the lowest positions of the power structure in the profession of what is a predominantly white-male one. This indicates barriers remain for not just Chinese, but also for women in finding work commensurate with their qualifications. The most common difficulty former students experienced when seeking work in this country was a lack of New Zealand work experience, with this lack of experience also being found to be an issue for former students, despite having gained a qualification in this country (Wilkinson et al., 2010).

An important feature of the Asian population is the level of education achievement and how this is realized in the workplace. Employment by Asians in New Zealand features a high number of people in professional occupations, 18% compared to 16% across the whole New Zealand population (Badkar and Yuya, 2010). Further, many more Asians, 49%, are employed in the health and community services sector as opposed to the 37% of the whole population. This is a reflection of the highly skilled and qualified nature of the Asian population in New Zealand. However, concern exists over an inability for some groups of migrants to attain employment that matches their qualifications. For some migrant groups, such as those from China and Korea, high unemployment rates exist, while some other groups, such as Indians, have high employment rates, their incomes do not reflect the income of other groups with similar qualification levels. Moreover, those Asians holding a bachelor's degree are much more likely to hold positions lower (33% as opposed to 11%) than their

degree would otherwise be utilised at and leads many Asians to being over qualified for their jobs (Badkar and Yuya, 2010).

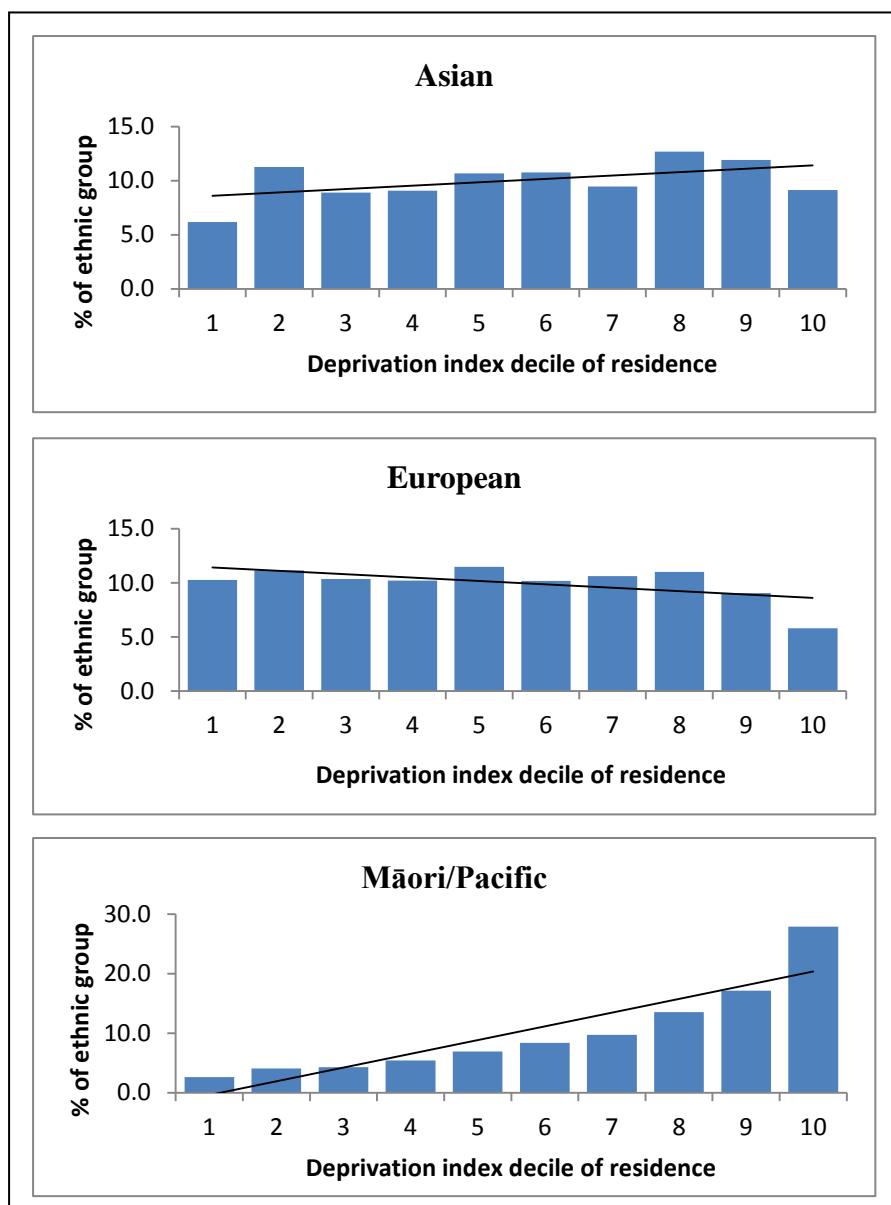
At the time of the 2006 Census the unemployment rate for Asians was 5.3%, but with the downturn in the economy this climbed to 9%, which is consistent with the national average. Of the sub-groups within the larger Asian population group North Asians were even less likely to be in paid employment at a rate of 4.9%. Though, this rate can in some way be attributed to the high number of North Asians in full-time study at school or university and not actively in search of employment.

### ***Housing***

Asian migrants, together with Pacific People, are among those least likely to own their own home. Multiple reasons can be suggested for this lower home ownership including lower incomes, as discussed above, or temporary migration status such as for those migrants in New Zealand for study. People of Asian ethnicities who have remained at their current address for more than five years are much more likely to own their homes (Statistics New Zealand, 2010a). More than half (54%) of Asians who have not moved and nearly 40% of Asians who have moved within New Zealand own their own homes. This high level of home ownership is reflective of the migration histories of the key Asian populations.

For both movers and non-movers, housing affordability is a factor. Asian home ownership is lowest in the Auckland region, but home owners still account for over 51% of those who have not moved elsewhere in New Zealand and 40% of those who have moved (Statistics New Zealand, 2010a). Similarly, main urban areas, which have higher proportions of rental accommodation, have lower levels of home ownership than smaller urban and rural areas. Despite this ownership pattern, for the Asian population this is relatively high, with 54% of Asians living in main urban areas owning their own homes compared with over 62% doing so in other areas.

In terms of socio-economic status, much like the European population, Asian people live in a mix of neighbourhoods as defined by the New Zealand deprivation index (Figure 3.9). However, in comparison to Europeans, Asian people are slightly more likely to live in more deprived neighbourhoods. This contrasts with Māori and Pacific people where a majority live in some of the most deprived areas.



**Figure 3.9** Percentage of ethnic groups and place of residence by deprivation index, 2006.

### ***Social Isolation***

Social isolation is very prevalent among the Asian population in New Zealand. To an extent some of isolation is derived from having recently arrived and lacking any level of integration, family separation, a cultural separation, or a lack of English ability. For older migrants and women with children there can be greater problems trying to build up supportive connections in the new place of residence (Mehta, 2012). These people are often left at home while other family members go to work or school in case of children. Many women are likely to suffer extreme social isolation due to migration having cut off their traditional sources of support. For older people isolation can come, despite being with younger family members, isolation can come from their adult children's and grandchildren's high levels of acculturation to New Zealand culture.

Loneliness has been reported to be a common issue for those in New Zealand on a temporary basis such as students, who for many have left home for the first time. Moreover, as they are temporary migrants, students are likely to have less social support than those residents who are more permanent.

### **3.5 Health outcomes for Asians in New Zealand**

This section will explore the health outcomes for Asians in New Zealand. Firstly, the section will examine the outcomes of the healthy migrant effect for Asians in New Zealand, followed with an exploration of the health outcomes for Asians in New Zealand, finishing with a brief overview look at the utilisation of health care by Asians in New Zealand.

#### ***Healthy Migrant Effect***

As indicated in Chapter 2 a so-called 'healthy migrant' effect occurs amongst first generation migrants, through which migrants are inclined to have better health status than

locally-born citizens. However, care should be taken in making assumptions that this effect will be in place for all migrants and for all health conditions. The effect also fades away over time due to the processes of acculturation and if migrants meet barriers to accessing health care services (McDonald and Kennedy, 2004).

A number of New Zealand studies have documented the short term negative impacts of migration on psychological wellbeing, particularly if migrants are not proficient in English, are unemployed following arrival in New Zealand or have low education levels (Abbott et al., 1999). The *Asian Health Chart Book 2006* (Ministry of Health, 2006) notes that better health status can be found among recent or first generation Asian migrants than New Zealand-born or long-term Asian migrants for the majority of the health indicators examined, but that this initial health advantage diminishes over time. Abbott et al., (1999) found a decrease in healthiness amongst Chinese migrants who had resided in New Zealand for five years or more having worse health outcomes than migrants who had been in the country for shorter periods of time.

Moreover, Asian New Zealanders born in this country are in general less healthy than recent migrants across a range of indicators including cardiovascular disease mortality, cancer mortality, and prevalence of health promoting behaviours such as exercise (Ministry of Health, 2006). This is not surprising given that most migrants to New Zealand need to be in good health to be allowed to enter the country and many have high socioeconomic status in their countries of origin. These migrant groups also have high levels of education which is frequently correlated with better health status.

### ***Health outcomes of Asians***

Compared with Maori and Pacific Peoples there has been a relative paucity of literature in New Zealand on the Asian migrant population and their health requirements. However, in recent years the level of research interest in the health of people of Asian

populations living in New Zealand has increased (e.g. Mehta, 2012, Scragg, 2010, Ministry of Health, 2006) Much of this research suggests that, in general, Asians fare better than the general New Zealand population as a whole on a range of health status indicators.

The 2011/12 New Zealand Health Survey indicated Asian people, on the whole, reported suffering from a lower incidence of ongoing health conditions when compared to the remainder of the New Zealand population (Table 3.6). With this lower reported incidence there is likely to be a corresponding lower frequency of health care utilisation by this ethnic group. However, with inclusion of all Asian respondents included at the Level 1 ethnic grouping and the effects of averaging, there may be some disguising of the health needs among the ethnicities at Level 2 and lower ethnic categories.

**Table 3.6** Percentage reporting suffering from selected health conditions by ethnic group.

	<b>High blood pressure</b>	<b>Heart disease</b>	<b>Stroke</b>	<b>Depression</b>	<b>Diabetes</b>	<b>Asthma</b>	<b>Arthritis</b>
<b>Asian</b>	10.4	1.9	1.1	4.3	6.2	4.4	7.2
<b>European/Other</b>	16.7	6.0	1.8	16.2	4.7	11.4	16.8
<b>Māori</b>	13.2	5.1	2.1	14.5	7.3	16.7	11.4
<b>Pacific</b>	11.3	1.7	0.6	5.3	10.2	9.3	6.6

*(Source: New Zealand Health Survey 2011/12)*

In addition, the 2011/12 Health Survey reveals good levels of health status and determinants amongst the Asian population as a whole (Table 3.7). In good and very good self-rated health the Asian population is very near the European/Other population and, as a group, have the lowest levels of cigarette smoking, obesity and are the most likely to have normal BMI. Nevertheless, the Asian group is the most likely to report being sedentary and second only to the Pacific group in eating the recommended daily intake of fruit and vegetables.

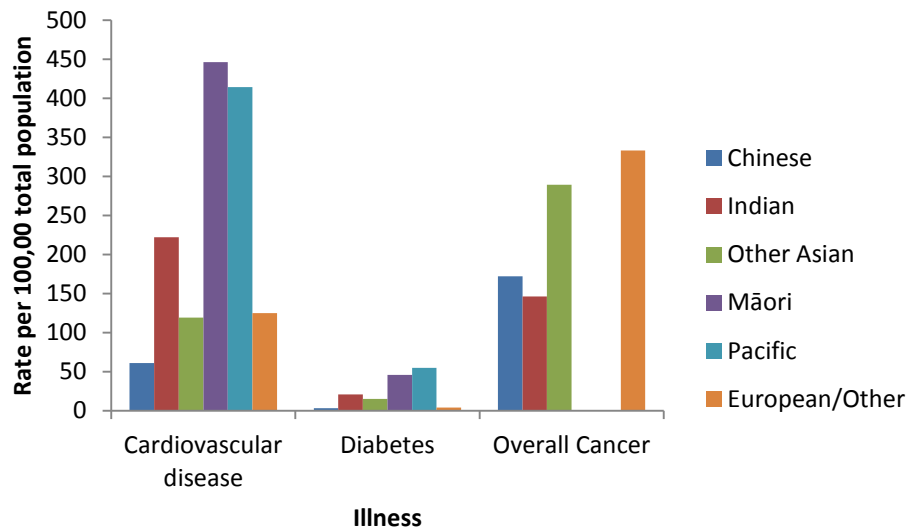
**Table 3.7** Percent of ethnic group self-reporting health status and determinants.

	<b>Good self- rated health</b>	<b>Poor self- rated health</b>	<b>Smoking</b>	<b>Fruit+ vegetable intake</b>	<b>Physically active</b>	<b>Obese</b>	<b>Normal BMI</b>
<b>Asian</b>	89.4	10.6	9.8	34.8	39.2	15.9	51.8
<b>European/Other</b>	90.0	10.0	16.7	47.1	55.9	26.0	35.2
<b>Māori</b>	83.6	16.4	40.9	37.4	57.1	44.4	23.8
<b>Pacific</b>	85.9	14.1	26.5	29.8	46.3	62.1	14.8

(Source: New Zealand Health Survey 2011/12)

Borrowing from a number of sources, Scragg (2010) reports a mixed pattern of healthiness and its determinants amongst Asians in New Zealand in relation to the length of time resident in the country with sedentariness decreasing with length of residence but increases in alcohol consumption and obesity. The only explanation given for this is a longer exposure to the New Zealand lifestyle (acculturation). These outcomes are further reinforced in the *Asian Health Chart Book 2006* (Ministry of Health, 2006) and the more recent *Health Needs Assessment of Asian people living in the Auckland Region* (Mehta, 2012) with each of these reports separating out Chinese and Indian ethnicities, but combine all remaining Asian ethnicities as ‘Other Asians’. The reports reveals generally positive health outcomes for a range of health indicators for the Asian ethnic groups compared to the total New Zealand population, but within the Asian group relatively high rates of obesity, type-2 diabetes and cardiovascular disease are prevalent amongst South Asians (Figure 3.10). This final point is linked to increased levels of sedentariness amongst the South Asian population after migration to New Zealand (Kolt et al., 2007).





**Figure 3.10** Mortality rate from selected causes for target populations per 100,000 total population. Overall cancer was unavailable for Māori and Pacific. Source: *Health Needs Assessment of Asian People in the Auckland Region* (Mehta, 2012).

Generally for most health indicators, recent or first-generation Asian migrants are reported to have better health outcomes than long-standing migrants or the New Zealand born (Ministry of Health, 2006). In due course however, this health advantage can be expected to dissipate as acculturation progresses for these groups and place effects create change in the health outcomes of migrants. While fewer Asians report being a daily smoker between the 2006 and 2011/12 health surveys, those reporting being physically active also decreases.

A community survey of 271 Chinese migrants aged 15 years and older living in Auckland was conducted to assess self-rated adjustment and health. The majority of respondents came from Hong Kong and Taiwan. Despite significant changes in their lives, including the absence of family members, unemployment and underemployment, most did not report major adjustment problems or regret having come to New Zealand. Few considered their health to be poor with 42% reporting having consulted a doctor within the past 3 months. Factors significantly associated with having experienced major problems included

rejection from locals (leading to isolation) and having low English proficiency. Factors associated with poor adjustment into New Zealand life included expectations of migration not having been met, regretting coming, low proficiency in English, recent arrival in New Zealand, unemployment, younger age and lower levels of education. Self-rated fair or poor health was found to be associated with Chinese-only reading knowledge, residency of more than 5 years and regretting having come to New Zealand.

Mental health issues also exist for Asians in New Zealand, as they do for any ethnic group. For many Asian people the discussion of mental health is not common, carrying social stigma and often no admission of some form mental health condition is forthcoming. The low incidence of self-reporting of mental health conditions in the New Zealand Health Surveys is indicative of this.

In a sample of 271 Chinese in New Zealand Abbott, et al., (1999) found that despite the overall prevalence of poor mental health in recent migrants appearing to be at a level similar to that of the general population, significant risk determinants were identified that included: poor adjustment including unemployment, low English proficiency, lack of university education, younger age, shorter residency. Predictors of more minor mental disorder included regretting coming, female gender and younger age (Abbott et al., 1999).

### ***Patterns of health service utilisation***

At a national level, patterns of health service utilisation have seen a decline for the total New Zealand population in relation to visiting a General Practitioner (GP). Data from the 2011/12 National Health Survey indicate that 81.3% in 2006/07 and 78.5% of the New Zealand population in the preceding 12 months saw a GP or GP nurse. However, the Asian ethnic population only slightly follows this trend in visiting a GP at 71.9% in 2006/07 and

71.2% in 2011/12. The cause for this decline in Asians visiting a GP is that the ethnic group is also the least likely to report any unmet need for any reason.

Rasanathan et al. (2006a) have shown, in their summary of the key health issues concerning the New Zealand Asian population, that a low pattern of levels of health care service utilisation, primary health care and cancer screening is seen across most areas for Asian people in New Zealand, particularly for Chinese. Some of this low utilisation may be related to the good health indicative of the Asian population, but also, in regards to cancer screening, stigma and issues of privacy frequently found in Asian people.

Young Chinese and Indian students in New Zealand, despite reporting personal health positively, were likely to report problems in gaining health care with reasons listed as not wanting to make a fuss, not being bothered and, for Chinese in particular, not knowing how to visit a doctor (Ameratunga et al., 2008). This indicates that for certain ethnicities communication at early stages of residence in New Zealand is lacking at some point showing point-of-entry education in native languages is required in immigration and health policy. These findings extend knowledge of the adjustment and the mental health of migrants and provide potential focal points for primary and secondary preventive interventions towards migrant healthcare.

### ***Responsiveness of the health system to the needs of Asian migrants***

Despite the growth in the Asian population in New Zealand the response to the health needs of Asians has, until recently, been one of neglect. And despite the issues in Asian health outcomes identified above in New Zealand research, there remains a policy void for the health of Asian peoples in New Zealand, with no apparent mandate to specifically consider or monitor Asian peoples when undertaking research or formulating policy. However, the function of health needs assessment is mandated by the Health and Disability Services Act (2000) in Clause 23, Functions of DHBs (1g):

...to regularly investigate, assess, and monitor the health status of its resident population, any factors that the DHB believes may adversely affect the health status of that population, and the needs of that population for services.

This clause would require the inclusion of the Asian populations with each DHB and for the DHBs to meet the needs of those Asian populations in accessing appropriate health care.

In answer to this requirement much of the response to the health needs of Asians has been centered within the greater Auckland region. This not surprising given the higher number of Asians living within this region and the tendency for migrants to settle in Auckland as the main point of entry to New Zealand for these people. A survey of the services available specifically targeting Asians in New Zealand reveals the greater proportion of the response has been carried out by the Waitemata District Health Board (WDHB). This is reflective of Asian ethnic group making up 14% of the population and as such is the second largest ethnic group in Waitemata.

The WDHB operates a number of programs targeting the Asian population within its own area and also, due to the close proximity of other health boards, has its services extend out to the wider Auckland region. Firstly, the WDHB provides a broad range of services directed towards the Asian population within its area of responsibility through the Asian Health Support Services (AHSS). The AHSS provides services to both the Asian population of the WDHB and to health practitioners (Waitemata District Health Board, 2008). As part of the AHSS is the Asian Mental Health Cultural Support Coordination Services.

A number of services are available in New Zealand that assists individuals with low English ability. Professional translation services are provided free of charge through the Language Line service (Internal Affairs, 2013). A number of translation methods are available, but perhaps most important for GP access and utilisation is the telephone

interpreting service with 44 languages offered. In addition, the Healthed website offers information in a number of languages including: Chinese, Japanese, and Korean which can be linked to through the New Zealand immigration webpage on health care in New Zealand (Healthed, 2011).

### **3.6 Primary Health Care in New Zealand**

The health system in New Zealand is, in principal, a tax-funded health system which at first glance appears much like the British National Health Service, including its provision of General Practitioner (GP) based primary health care. Yet, while hospital care is 100% funded in the public setting, New Zealand differs from the British model due to primary health care being only approximately 60% funded by the government. Because of this funding structure patients are required to make co-payments towards their visits for a GP visit. The local doctor or GP is generally the first point of contact with the health care system for nearly all New Zealanders. GPs operate as private businesses and set their own fees for consultations and other services. A visit to a GP is also required for referral to secondary and tertiary levels of care.

Funding to GPs is generally provided by District Health Boards contractually through Primary Health Organisations (PHOs) to provide a specified set of treatment and preventive services to their enrolled populations regardless of whether contact is made with a patient or not. The central feature of the strategy is the grouping of the primary care providers, GPs, primary care nurses and other health professionals such as Maori health providers and health promotion workers, into PHO networks. PHOs were created with equity of health care as the goal. PHOs, which are third sector organisations, are funded on a capitation model (i.e. population based funding formula) that includes age, gender, deprivation and ethnicity components. However, the funding formula only prioritises two ethnicities, Māori and Pacific

people, and does not consider Asian people in any specific way. The funding formula also prioritises those living in the most deprived areas, deciles 9 and 10, and thus those Asians living in these areas will be included.

This health care structure of PHOs with its community governance and capitation funding system was an outcome of the 2001 Primary Health Care Strategy brought in by the Labour Government of the day. The 1970s did see the creation of a small number of low fee ‘Health Unions’ in some of the more deprived communities in New Zealand, however, prior to the creation of PHOs successive governments had been notably unsuccessful in confronting inequity in health access. The creation of PHOs saw capitation based funding move from a minority contribution model into the dominant model of health funding. New Zealand has not moved completely away from a fees-for-service as a co-payment is still required from patients for the cost of a consultation.

### **3.7 Conclusion**

This chapter began by describing Asian migration trends into New Zealand, examining the scale of Asian migration to New Zealand following the transformation of New Zealand’s immigration policy from 1986 opening the way for increased Asian migration. The first section also explored some of the distinctions and similarities between each of the three migrant ethnic groups under scrutiny in this thesis and how migration and settlement has occurred for each in New Zealand. The second section of the chapter described the experiences Asians have encountered in living in New Zealand. This showed that for Asian people migrating to New Zealand discrimination exists in the workplace and elsewhere, but socially Asians are finding their way into mainstream life through social institutions and activities. However, Asian people in New Zealand can frequently be found within the lower

economic strata of society, which in turn may influence their ability to access adequate health and health care solutions.

## **Chapter 4 Research Methods**

### **4.1 Introduction**

This chapter details the methods and processes employed to acquire and analyse the information through this thesis. As this thesis was predominantly concerned with the various perceptions held by certain Asian populations on primary health care in New Zealand, the research methods used were qualitative. While some quantitative methods were used to describe national health utilisation and outcomes from the 2011/12 National Health Survey, qualitative methods were employed to address the aims of this thesis.

This chapter is organised as follows. First, the methodological approaches used in geographical research on migration are discussed, second the data sources used to meet the objectives are described, and this is followed by a discussion of the methods used to achieve the thesis objectives. Finally, the limitations of these methods are explained.

### **4.2 Positionality**

Before the methods used in this thesis are discussed the issue of positionality needs to be addressed. There is a need to discuss the values of the researcher that might affect data collection and analysis (Merriam et al., 2001). This is because the researcher constructs meaning in connection with his/her own experience. When researchers interview their participants their experiences may influence what they ask and what they hear from their participants. If another researcher with different experiences were to interview those participants, read their transcripts, and analyse the data, the findings and the interpretations may be different from the interpretation of others because of the different attributes that they have.

However, positioning is not as simple as a binary notion of ‘insider/outsider’, and debates within geography have lead to increasing criticisms of the concept and sought to



provide new ways of understanding difference. Personal relations of the researcher/researched dynamic are not reducible to a simple insider/outsider dimension (Miles and Crush, 1993) and sharing a characteristic such as skin colour or gender is not necessarily enough to establish an open research exchange (Dyck, 1997). As Rose (2012) emphasises, the uncritical use of the notion of 'insider' brings with it the danger of essentialism. It is therefore important for researchers to position themselves by describing who they are and why they are doing the research.

Thus, the author is not Asian and can be seen as an outsider. However, his partner is Japanese and he has spent many years in Japan and other parts of Asia. That the author's wife is Japanese is going to create and influence sympathies towards her health care needs and her experiences with health care services in New Zealand, whether positive or negative. Further, having lived in an Asian country for many years, and having an intimate relationship with that culture, the author can also be seen as an insider. Care can be taken in filtering out these sympathies, but they will not be totally removed.

#### **4.3 Methodological approaches in geographical research on health**

Quantitative approaches have been widely used in geographic research on migration and the health and health care outcomes stemming from the movement of people. Quantitative methods have important advantages from a public health perspective, such as in the examination of diseases quantitative methods can assist in revealing the relationships between an individual and wider-level risk factors and disease and the determinants of ill-health, providing evidence of the cause (Elliott and Baxter, 1994). Such methods can measure the magnitude of the associations between features of specific places and health outcomes. In geographical research more widely, Dorling and Shaw (2002) have shown the importance of

quantifying arguments for policy-related work in order to show how much a particular problem matters and how it can be influenced. Therefore, quantitative approaches to migration and health research can determine how far relationships between health and places are generalisable or variable across whole populations (Cummins et al., 2007). Moreover, the use of geographical quantitative techniques can identify specific areas with high incidence of disease or various health-related behaviours, and can accordingly aid health care planning initiatives. Quantitative methods can be employed to assist policy makers in deciding on the type of health care services required, and where to optimally locate them within communities (Curtis and Tacket, 1996). Examples where these approaches have been applied include the locating of an optimal site for a cervical cancer unit in Trent, England (Smallman-Raynor et al., 1998) and of private health care services in India (Kumar, 2004). Geographical quantitative methods have also been used to the effects of cigarette and alcohol outlets placement on health outcomes.

While much of previous research on migration and health has been quantitative in nature, qualitative methods are also increasingly being employed (e.g. Elliott and Gillie, 1998, Dyck and Dossa, 2007, Lee et al., 2010a). Qualitative methods are those such as interviews, participant observation or focus groups and are inductive in nature. These methods have assisted the sub-discipline of health geography connect with the theoretical developments occurring in mainstream geography (Brown and Duncan, 2000). The purpose of qualitative research is not only to identify and describe multiple meanings and interpretations of events and places, but also to interpret them within their social context (Kitchen and Tate, 2000). Qualitative methods have been proposed as a way of providing opportunities for individuals to speak for themselves and understand their own experiences, and of allowing researchers to draw out the variety in people's lives (Pain et al., 2000), providing contextual data about the concerns of individuals enriching understanding (Elliott and Baxter, 1994). As Cummins et al.

(2007) have noted qualitative studies into health care are valuable because they provide insights that illustrate how conditions in particular places are thought to influence health, and they are “powerfully suggestive of causal pathways” that link environmental factors to individual health (p. 1826).

Further, qualitative analysis allows a focus on the everyday life situations, attempting to formulate questions and answers on the basis of the patterns that emerge during the research investigation. Research does not attempt to manipulate the settings for the study purpose, but instead endeavors to contrast, catalogue and compare the subject under study (Caudle, 1994). Qualitative research traditions focus inquiry onto an individual’s experiences and the experiences of a number of individuals about a particular subject, including in health services research. However, qualitative research of the use of health services has had a limited showing within health or medical journals over the years with recent calls for change (Hoff, 2011, Gagliardi and Dobrow, 2011).

Where qualitative methods have been used in health services (Stead et al., 2001, Thompson et al., 2009) research they have been able to provide much useful insight into the socio-cultural influences on access barriers and have been used widely in research into health services utilisation by migrant groups. An example is that of Gideon (2011) who drew on a small case study analysis using semi-structured interviews conducted with Latin American migrants in London and other relevant stakeholders (e.g. health providers) to examine the health seeking strategies of these migrants in London. The author highlights that despite Latin American migrants having entitlements to use the NHS, a series of informal barriers limits their access and in consequence many employ a range of “transnational health-seeking strategies” in response to unresolved health problems. Strategies included returning home to Latin America for health care, calling doctors in Latin America and using Spanish speaking doctors in the UK. As with Asian migrants in New Zealand, the author points to the

heterogeneity of the Latin American migrant community in the UK that warrants a more detailed study of the migrant group.

Qualitative methods have also been used to identify and explore barriers to health service use. In an exploratory study exploring the barriers to mental health services use by Chinese migrants to Australia, Blignault et al. (2008) conducted in-depth interviews with China-born mental health patients and mental health service providers. The interviews identified barriers such as stigma, concerns with confidentiality and communication. The authors were able to use the interviews to explore deeper understandings to communication barriers and were found not to be simply a case of hearing words, but also from the comprehension of socio-cultural idiom and references. Such understandings are possible through qualitative methods, providing flexibility to the researcher during the interview process, where a quantitative method may have caused the deeper findings to remain buried.

#### **4.4 Data Sources**

Data for this thesis were from two sources. The primary data were from interviews with Asian migrant participants from the Chinese, Japanese and Korean communities in Christchurch and with people involved with health care funding, provision and delivery. Secondary data used was enrolment data and national health utilisation data.

##### ***4.4.1 Primary Data sources***

The primary source of data in this thesis is through two series of interviews. The first series of interviews were to achieve the objectives of the first three research questions (see section 4.4), while the second series of interviews were conducted to meet the objectives of the fourth research question.

Interviews were carried out with participants from the three ethnic communities of interest in this thesis (Japanese, Korean and Chinese). The demographic nature of the

interview participants is outlined in Table 4.1 (see Appendix 1 for a more detailed description of the individual participants). This sample is not representative of the three ethnic groups in Christchurch. The sample is weighted strongly towards female participants (72%), when the Asian gender distribution in Christchurch is 47% male and 53% female. A majority of the participants came to New Zealand as migrants, with only one male ethnic Korean having been born in New Zealand. The length of time the participants had been in New Zealand varied greatly with the shortest time being 1 year and the longest 30 years, though the median and mode time lived in New Zealand was 7 years.

**Table 4.1:** Demographic nature of participants.

Ethnicity	Sex		Age Group						Total
	Male	Female	20-29	30-39	40-49	50-59	60-69	70+	
<b>Chinese</b>	6	17	1	1	1	9	8	1	23
<b>Korean</b>	4	17	2	8	5	3	1	1	21
<b>Japanese</b>	8	13	0	6	12	2	1	0	22

Interviews carried out with a number of key people involved in health care delivery and connected to health care policy were also used to understand how the health needs of the Asian population in New Zealand have been met by the health sector. These key people included chief executive officers, health promotion coordinators with five PHOs in Auckland and Christchurch, health practitioners, including GPs and nurses, in general practices in the same cities. In addition to these interviews with health providers, interviews were also carried out with four Members of Parliament who had a direct interest in Asian health concerns.

### *Choice of ethnicities*

Three ethnicities were chosen as the foci cultures within this thesis: Korean, Japanese and the broader Chinese ethnic group. These three groups were chosen due to little research on the Korean and Japanese community in New Zealand in relation to their health care utilisation. After consultation with a representative of the then PHO Partnership Health Canterbury, one with a Chinese partner, it was decided to include the Chinese ethnic group to keep the ethnic groups of interest within the North Asian area. More importantly, during initial consultation with a PHO representative this ethnic geographic area was identified as one of concern in terms of their low health service use. The North Asian ethnic group was also of interest as these countries generally have very different systems of health provision to that of New Zealand. The first-generation Chinese, Korean and Japanese were seen as an appropriate study population given their likelihood of having experienced medical care in their home-countries prior to moving to New Zealand. The Japanese ethnic group was also of personal interest due to the writer having lived in Japan and also having a Japanese partner.

#### *4.4.2 Secondary data sources*

Secondary data sources were used to explore the level to which the Asian population utilised health care in New Zealand. Data tables (Table 4.2) freely available through the Statistics New Zealand and Ministry of Health websites were collected for re-examination and presentation.

**Table 4.2:** Secondary data sources used in this thesis.

<b>Data</b>	<b>Data Source</b>
<i>Enrolment Data</i>	
Ethnic group (Level 1 grouped total responses) for the Census Usually Resident Population Count, 2001	2001 Census of Population and Dwellings Statistics New Zealand
Ethnic group (Level 1 grouped total responses) by DHB for 2006	2006 Census of Population and Dwellings Statistics New Zealand

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PHO/DHB enrolment demographics 2013Q2	Ministry of Health
<b><i>Health Survey Data</i></b>	
Data-tables- 'health service use'	2011/20 New Zealand Health Survey
Data-tables- 'health conditions'	2011/12 New Zealand Health Survey

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### ***Enrolment Data***

To explore the number of Asians enrolled with a PHO in New Zealand, and thus the rates of utilisation of primary care by Asians, a population projection for 2013 was compared with the PHO enrolment data. To calculate the population projection for the year 2013 the DHB ethnic group population from the 2001 and 2006 New Zealand Censuses of Population and Dwellings were used. This projection was necessary owing to the cancellation of the 2011 census (as a result of the 2010/11 Canterbury Earthquakes) and the unavailability of the 2013 census at the time of thesis completion. A 2013 population (projected or otherwise) was desired to compare to the up-to-date enrolment data that was available from the Ministry of Health. The population projection was calculated from the difference in populations between the 2001 and 2006 census, dividing by each year and then projecting forward for the number of years to 2013. The linear projection derived was completed for the total New Zealand population and for the Asian population. There is an issues with this population projection which needs explaining. While the DHB/PHO enrolment database provides an up-to-date count of enrolled patients, there are a number of issues with the DHB enrolment data presented. Firstly, estimated total population projections have been used as the denominator to calculate the proportion of each ethnic group in New Zealand that is enrolled with a PHO. These projections are the best available estimates of population counts given the cancellation of the 2011 census due to the Canterbury earthquakes.

### ***Health Survey Data***

To explore the level of utilisation of health care services in New Zealand by Asian people data-tables for the 2011/12 National Health Survey were obtained from the Ministry of Health. The data-tables provide a statistical summary for the key health indicators used in the survey and are available in Excel spreadsheet format allowing further exploration of the data and were used to explore a number of indicators including: health service use (e.g. having seen a GP within the previous 12 months, or having experienced unmet need over the same period), health conditions (e.g. diabetes) and health status (e.g. obesity). These health indicators were compared to the 2006/07 National Health Survey to determine the extent of change.

In comparing health utilisation between the two survey years an issue of comparability was encountered. The questions between the 2006/07 and 2011/12 surveys were changed to ask more directly about unmet need. This was because it was discovered issues existed with how people were answering the 2006/07 version, during cognitive testing of the questionnaire in preparation for the 2011/12 survey, which meant there was underreporting of unmet need due to cost. These changes made the results incomparable for this indicator.

## **4.5 Methods**

The dominant method used to address the research questions in this thesis was a qualitative approach which used semi-structured interviews. A qualitative approach was chosen as it allows participants to respond to questions in their own words, providing a much richer form of data, something a quantitative method frequently prohibits. Quantitative methods, such as surveys, often limit responses to predetermined answers providing a narrow space for respondents' to voice their concerns. A focus group method was also proposed, but



consultation with the ethnic communities indicated there would be reluctance by the ethnic group's members to speak of their health care experiences in a more public forum. An issue Elliot and Gillie (1998) also noted in working with Fijian Indian women who were reluctant to speak outside of the family home in a more public environment. (For more on the cultural aspects of focus groups, see 4.7.) Interviews help to answer how events, practices or knowledge are constructed and enacted within a particular context and assist the researcher to drill down to a personal level in exploring individual experiences within the topic under consideration. The interviews were carried out with the Asian participants on a one-on-one basis and always in person (face-to-face). The recruitment and interviewing of participants was carried out over the three months of March, April and May in 2013.

### ***Interview recruitment***

A number of avenues were explored and employed in recruiting participants to this project with two in particular proving particularly successful. Initially, it had been proposed to recruit participants through GP clinics. This method would have provided direct access to health service users and through these participants the potential recruitment of not-enrolled members of the Asian community. PHO representatives were reluctant to support the method, suggesting GPs would not want a researcher interviewing their patients for feedback on health services. Other means to recruitment were found to be as beneficial.

Firstly, classes run for English for Speakers of Other Languages (ESOL) were approached in a number of locations. These locations included within a larger high school that offer such lessons to the wider community of Christchurch and churches which host ESOL. Secondly, ethnic specific churches were approached, namely the Christchurch Chinese Christian Centre and the Christchurch Korean Full Gospel Church.

One source of ESOL class participants was through Hagley Community College which operates two differing systems of language instruction to students of English as a second language. The first was the common ESOL classes at the Hagley English Language Centre, while the second was a part of the Hagley Adult Literacy Centre, commonly referred to as HALC, which also offers instruction in English language. This use of ESOL classes facilitated not only the recruitment of participants with a varied level of English ability, but also a mixture of ethnicities. Another location of ESOL classes utilised in this project are those sited in churches. Churches frequently provide space within their facilities to bring together community members, with the fees for lessons set at nominal amount. At one location this was a single gold coin per lesson and thus participation was often high. These two forms of ESOL classes feature longer term residents/migrants, and not those in New Zealand specifically for language courses at the commercial language schools. The class attendees are more likely to be utilising health care on a more regular basis than if only in New Zealand on a short term visa.

However, a limitation of this recruitment method is the age structure of the Asian participants in the study. Due to the recruitment being conducted in language classes taking place during the day, that are for the most part attended by adults, there was a tendency for the students to be older members of the community. Further, those going to ESOL classes are not likely to be suffering from any isolation issues, and actively participating in society.

Church member participation was forthcoming once participants gained confidence and understood why the researcher was at the church wanting to talk to them. This process was assisted by a church member taking the role of guide who was able to introduce and explain the purpose of the research. To some extent having a guide also acted to produce a gate-keeper. The guide had an intention to ask only those church members with a high level of English ability, where those with all levels were desired, because this would have helped determine

language as being a factor in utilisation of health care. While gatekeepers often undertake actions that may be understood as primarily protecting individual interests within a group (Gallo et al., 2012), as in this case they can also work to hinder an important aspect of the research objectives.

Further, explanation of the research project also took some time when a potential participant was first approached. Potential participants felt they could be of use to, and be more willing to participate in, the research if they were told of the type and range of questions to be asked rather than simply being told what the project's aims were. Confusion also arose where a participant felt they were not an appropriate participant if they were a low user of health care in New Zealand.

### ***Interview procedure***

A semi-structured interview method was used. An interview guide was utilised to focus questions to uncover specific accounts and interpretations of that health care utilisation. The guide structured questions into groups that reflected the research questions (Appendix 2). The interview questions were also informed by the wider research literature on health care utilisation. In considering to what extent perceptions and experiences of health care in New Zealand created barriers to utilisation of health care interview questions explored participants' reasons for enrolment and seeking health care, the problems they had experienced when visiting a doctor and the aspects they found good or disappointing with that visit. To explore how 'home country' health experiences influenced health care utilisation interview questions considered patterns of health care utilisation before and after migration, the reasons they might have had for seeking health care and where they sought health care (e.g. family, specialist or alternate medicine). To investigate the extent modes of acculturation had in influencing utilisation of primary health care interview questions focused on the length of

time participants had been in New Zealand and how soon after arrival they had sought health care, how participants had been introduced and learnt about health care in this country.

Due to participants' potential language limitations a static questionnaire or strict interview script would not have allowed for a thorough probing of each individual's encounters with health care. A semi-structured question guide allowed flexibility to adapt questions to the language needs of each participant, providing flexibility to rephrase each question for comprehension as need arose. Further, by keeping the interviews semi-structured, it allowed the researcher to adopt an adaptive approach and collaborate with the participant in an ongoing dialogue where the interview could precede at a pace suitable for the participant creating a mutual understanding.

The interviews were conducted in a number of places, being dependant on the method of recruitment. The Hagley Community College ESOL staff were kind in providing an empty classroom available on the days interviewing took place and the church found a quiet room for the same purpose. On occasion the interviews were also conducted in the private homes of the participants when this was more convenient for the person being interviewed.

All of the participants had a reasonable level of English, not lower than the Preliminary level of the Cambridge ESOL exams (the second tier of the Cambridge ESOL Exams). This level was selected as a participant selection criteria as speakers at this level of English proficiency are seen as being capable of everyday English use in normal settings, such as visiting a doctor. Technical or medical jargon may still be beyond the patient at this level of English, but would still be able to call for an appointment or attend the consultation with minimum confidence. Due to the varying levels of English language proficiency present amongst the participants interviews varied substantially in depth and length.

The recruitment methods garnered 66 interviewees in total. These interviewees included 23 Chinese from mainland China (15), Taiwan (7) and Hong Kong (1), 21 South Koreans and

22 Japanese (Table 4.1). For a more detailed description of the respondents refer to Appendix 1. It should be noted respondents in this thesis are not considered to be a representative sample of all Japanese, South Koreans or Chinese in Christchurch.

To understand how policy and practice within the health sector have responded to the health needs of Asians, a series of interviews were conducted with key people within five PHOs and those medical practitioners with increasing interest in health provision towards the Asian communities in the greater Auckland area and Christchurch. Sampling for this section was purposive in that participants who were relevant to the research project strategically selected. Three of the PHOs were in the greater Auckland area and had high Asian enrolments. To carry out these interviews I travelled to Auckland in June, 2013 and while in Auckland I also met with a GP of the same ethnicity as one of my selected ethnic groups. In Christchurch I met with representatives of the metro focused PHOs, as well as a Christchurch based Asian health promoter within a national screening program. The interviews with the PHOs' representatives included chief executive officers and health promotion coordinators (including mental health) within the PHOs. The interviews with health practitioners included ethnically Asian GPs and nurses, three of whom had been trained in New Zealand with one nurse having been trained in the United Kingdom.

As well as to the interviews with the direct contact health sector in New Zealand, contact and interview participation was made with a number of Members of Parliament (MP) with a direct interest in migrant health concerns. Interviews with the MPs were conducted over the telephone.

#### **4.6 Ethics Approval**

The research conformed to the University of Canterbury's Code of Ethical Conduct for Research Involving Human Participants. Certain criteria required being met before ethics approval was granted. An informed consent was required from participants before the

interviews began with an explanation of the procedures, benefits and risks of participation. For Asian cultures which prefer more explanation as to why something is being done the consent form was extensive, detailing these benefits and risks. Sensitive issues can be shared in an interview, and it was important that the participants trusted the researcher and information was not taken out of context and would not be further distributed. No incentives were to be used to recruit participants, though a small chocolate was given to participants at the completion of each interview. This was advised by community advisors as being a culturally sound best practice. Giving a small gift was a sign of thank you and acknowledged that participants had given something personal.

#### **4.7 Limitations with data collection methods**

The research process had a number of key limitations: availability of regional data on Asian patients, recruitment of more un-enrolled participants, and running of cross-cultural focus groups.

To explore the differences between Asian ethnicities in their patterns of utilisation of health care in Christchurch, New Zealand, was not possible due to the lack of data available on the different Asian ethnicities at the Level 3<sup>8</sup> category. For details what constitutes the Level 3 ethnic category please refer to Table 3.1. The 2011/12 national health survey contained only 71 Asians of all ethnicities in the Canterbury District Health Board, negating any potential of analysis at the regional level.

A snowballing method in recruiting beyond those met through community organisations such as the ESOL classes and churches, been identified as a reliable method to contact and recruit hard to find, out of the way individuals (Streeton et al., 2004). It was hoped to locate those members of the ethnic communities who may be for some reason isolated and had not been able to enrol with a GP for whatever reason. Ultimately, this method proved unsuccessful,

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<sup>8</sup> The Level 3 category is defined in Chapter 3.

resulting in only one more participant being recruited. Those participants asked if there was anyone they could introduce to the project were reluctant to recommend participation to other people for two reasons: cultural and obligation. The cultural aspects involved were that to recommend to another person to participate would put the participant in a position of awkwardness and embarrassment. The reasons behind this were explained as such: asking can create awkwardness between the two people where extended explanation is required for the second person to understand the request and what it is for, being that the first person does not want to have to do so. When the second person declines to participate, there can be some newly raised barrier between the two people, who may previously have had a close relationship. The promise or offer to find others for the researcher could also create an obligation towards the researcher that may not be fulfilled, producing embarrassment for the participant.

Focus groups, with a mixed ethnic make-up to help gain an understanding of difference in attitudes and perceptions towards health care and its provision in New Zealand, were suggested as a means to acquiring a richer insight into the views and perceptions of people in a particular context (Doumit & Nasser, 2010; Dyck, 1999). Focus group style methods can frequently provide a rich narrative as participants converse, eliciting further ideas and opinions as others speak. However, a majority of the interview participants were reluctant to involve themselves further in a focus group. It was explained by one key member within the Asian community that for many within these cultures health issues are a private matter and to discuss them in public went against social etiquette. While participants were happy to discuss perceptions and stories of their own health care experiences to the interviewer, someone not of their culture and immediate community, to so discuss such in front of people they may know also raised issues of perceived or actual loss of face. The individual Korean and Japanese ethnic communities in Christchurch are small with members frequently knowing each other and are, as such, frequently not strangers to one another.

## **4.8 Conclusion**

This chapter has described the methods used within this research, outlining why these methods were chosen. Qualitative methods were chosen as they allow the researcher to focus on the everyday life situations of subjects and to ascertain the patterns that come out during the research investigation. They provide opportunity to expand and flow with the research process. The following chapters will present the analysis of the outcomes of these methods. This study offers an examination of some of the experiences and concerns expressed by the respondents and should assist our understanding of the influences affecting Asian utilisation of health in Christchurch, New Zealand.



## **Chapter 5 Response of the health sector to health care utilisation by Asian populations in New Zealand**

### **5.1 Introduction**

This chapter explores how the health needs of the Asian population in New Zealand have been met by the public health sector. To achieve this aim the chapter is divided into three sections. The first section explores patterns of utilisation of the Asian population in New Zealand as a whole, reviewing the statistics of unmet need. The data used in this section is that from the available PHO enrolment database available from the Ministry of Health and the 2011/12 National Health Survey. The second section reviews the response of the public health sector to Asian health needs. The third section reports the views of health professionals from medical practices with predominantly Asian enrolled patients.

### **5.2 Patterns of health care use by the Asian population**

Use of health care explored in this section includes focuses both upon patterns of enrolment with a primary health care provider, normally a GP, as well as the extent of GP utilisation by the Asian population.

#### ***5.2.1 Patterns of enrolment by the Asian population***

Enrolment is the registration of an individual with a GP and through the GP with a PHO. Enrolment in a PHO is voluntary, but people are encouraged to join a PHO to access the benefits associated with belonging to a PHO. Benefits can include cheaper doctor's visits and reduced costs on prescription medicines. GPs normally charge a higher fee, frequently called a casual rate, for patients that are not enrolled at their practice. It is free to enrol with a GP, but they may charge a consultation fee for each visit after that.

For an understanding of the level of the Asian population enrolled with a PHO in New Zealand published enrolment demographics were compared with a population projection. As the 2013 New Zealand census had not been released at the time of thesis completion<sup>9</sup>, a linear projection was created for 2013 by calculating the difference between the 2001 and 2006 censuses and then dividing the result for each year. This yearly growth rate was then projected forward to provide an estimated projection for 2013. While Statistics New Zealand provides population projections, this was not provided for 2013 and population projections are not provided for the DHBs. This projection has been compared to the 2013 second quarter DHB primary health provider enrolment database for each DHB (Table 5.1). These are then ranked by percentage of Asian population enrolled.

As was shown in Chapter 3, the Asian population is concentrated in the North Island, particularly in the greater Auckland region, and to a lesser extent in Wellington. While Canterbury has the largest concentration of Asians living in the South Island (8%), this number is considerably lower than that of the aforementioned and is similar to the numbers in Hutt and the Waikato districts at 9.1% and 6.9% respectively. These concentrations of the Asian population distribution in New Zealand are reflected in the numbers enrolled with a GP and PHO, with those DHBs with larger Asian populations having high enrolment rates, whilst the opposite is also true. The differences in projected populations and enrolled populations appear to be negligible, with a low un-enrolled population. The differences between the percentage values of those domiciled within a DHB area and those enrolled with a GP/PHO are given in here in the final column of Table 5.1. A positive value is indicative of an under enrolment, while a negative value indicates a higher number of people being enrolled than the population projection indicated as living with the DHB.

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<sup>9</sup> At the time of thesis completion Statistics New Zealand had released total population figures from the 2013 census by region, but ethnic data was not as yet available.

**Table 5.1:** 2013 population projection and 2013 2nd quarter PHO enrolments by DHB.

	<i>2013 Population Projection</i>			<i>2013 DHB Enrolment</i>			
<b>DHB</b>	<b>Total 2013<sup>1</sup> population projection</b>	<b>Asian 2013<sup>1</sup> population projection</b>	<b>% Asian/Total population</b>	<b>2013Q2<sup>2</sup> Total</b>	<b>2013Q2 Asian</b>	<b>% Asian/Total population</b>	<b>% Difference total/enrolled</b>
Auckland	456258	133574	29.28	431,691	100,839	23.36	5.92
Counties Manukau	513659	112058	21.82	498,085	86,582	17.38	4.43
Waitemata	554212	104972	18.94	527,322	80,325	15.23	3.71
Capital and Coast	295747	34809	11.77	277,222	27,862	10.05	1.72
Hutt	142052	12889	9.07	140,529	12,143	8.64	0.43
Canterbury	521465	41861	8.03	485,760	29,678	6.11	1.92
Waikato	369209	25508	6.91	361,984	18,954	5.24	1.67
Midcentral	164242	8812	5.37	157,296	6,765	4.30	1.06
Lakes	96774	4491	4.64	103,065	3,040	2.95	1.69
Southern	303184	12193	4.02	285,962	8,405	2.94	1.08
Bay of Plenty	218405	7723	3.54	209,796	6,867	3.27	0.26
Taranaki	106033	3062	2.89	107,100	2,422	2.26	0.63
Hawke's Bay	154829	4330	2.80	152,570	3,795	2.49	0.31
Whanganui	60275	1619	2.69	60,493	1,065	1.76	0.93
Nelson- Marlborough	140688	3191	2.27	137,973	3,180	2.30	-0.04
Northland	160078	3395	2.12	162,611	3,166	1.95	0.17
Tairāwhiti	45152	880	1.95	46,088	678	1.47	0.48
Wairarapa	39180	683	1.74	41,871	626	1.50	0.25
South Canterbury	55410	918	1.66	56,747	1,107	1.95	-0.29
West Coast	32771	484	1.48	31,863	568	1.78	-0.31
<b>Total</b>	<b>4429623</b>	<b>517452</b>	<b>11.68</b>	<b>4,276,028</b>	<b>398,067</b>	<b>9.31</b>	<b>2.37</b>

Data Sources: <sup>1</sup> Ethnic group usually resident population for 2001 and 2006 censuses grouped total responses, Statistics New Zealand. <sup>2</sup> PHO/DHB enrolment demographics 2013Q2, Ministry of Health.

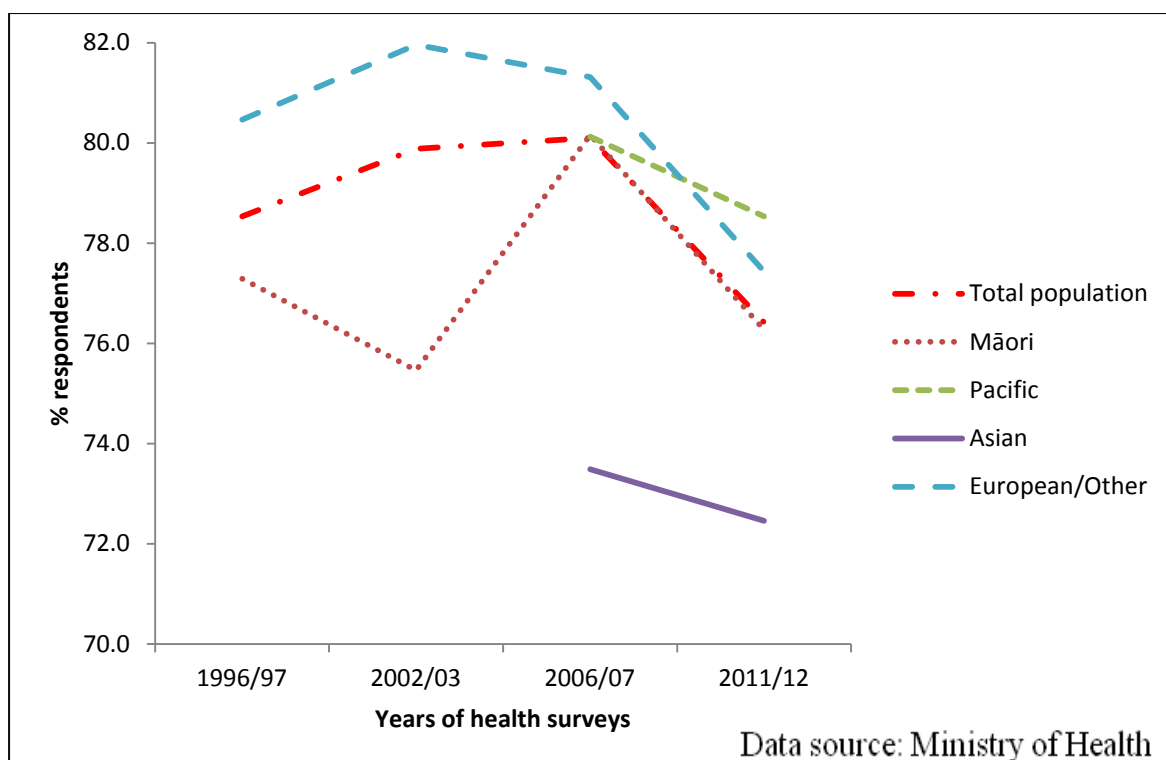
Of note is the difference between the number of people projected as being domiciled within Auckland and the number of people not enrolled. While there will be some members of the community who have not enrolled with a GP/PHO, a notable proportion of the Asian population of Auckland is likely to be students and who may seek primary care as an un-enrolled patient (Mehta, 2012). These people will do so due to those people on a student visa are ineligible for public health care and are required to have private health insurance.

While the DHB/PHO enrolment database provides an up-to-date count of enrolled patients, there are a number of constraints with the DHB enrolment data presented here. Firstly, estimated resident population projections have been used as the denominator to calculate the proportion of each ethnic group in New Zealand that is enrolled with a PHO. These projections are the best available estimates of population counts given the cancellation of the 2011 census due to the Canterbury earthquakes; they therefore cannot be accurate and may have resulted in an exaggeration of over-enrolment in the enrolment rates presented above. These results differ greatly from enrolment figures elsewhere which used earlier projections available from Statistics New Zealand (Mehta, 2012). Additionally, a recent report highlighted a study carried out in Auckland which noted significant inaccuracies in the ethnicity coding at primary care practices, which makes problematic the accurate reporting of ethnic enrolment. It is intended that a PHO receive funding from a single DHB, but PHOs frequently operate across DHB boundaries which can serve to confuse where a patient is recorded as being enrolled. The PHO enrolment database also uses DHB of domicile where available, but it has been found this is not recorded in the database for around 30% of patients (Mehta, 2012). For these patients, the DHB has been included according to the PHO's location which will lead to a numerator/denominator disparity for those patients whose PHO falls into a different DHB from their DHB of residence.

### 5.2.2 Utilisation of GP services

For most people general practitioners, often referred to as family doctors, are generally the first point of contact with the health care system in New Zealand. GPs usually work in general practices or medical centres, along with practice nurses and other health professionals such as counsellors or alternate health practitioners (e.g. acupuncture). Along with practice nurses, GPs are an integral part of primary health care in New Zealand with their work including preventing, diagnosing and treating health problems. GPs, along with practice nurses and other health professionals who are suitably qualified to do so, can also refer patients to specialist health services if needed. It is generally necessary to visit a GP before receiving a referral to a specialist at the secondary or tertiary care level. Thus, visiting a GP is important in terms of a person's overall health/medical care.

Asian people, as a group, were less likely to have visited a GP in the previous 12 months prior to the survey than any other ethnic group. The utilisation of GPs has decreased for all ethnic groups between the 2006/07 and 2011/12 health surveys (Figure 5.1). This is a considerable change from the period between two previous surveys (2006/07 and 2002/03), which had seen a major increase in the number of Māori reporting that had visited a GP in the last 12 months. This increase for Māori and Pacific People is to some measure related to the focus of the 2001 *Primary Health Care Strategy* on Māori and Pacific People and a reduction in the cost to visit a GP. However, the cause for the drop in visits to a GP in the following period may also be related to cost related issues. Unemployment increased over this final period due to the global economic downturn which may have affected peoples' ability to pay for health care. While still having declined over the period between 2006/07 and 2011/12, in line with other ethnic groups, the rate of decline is much less significant.

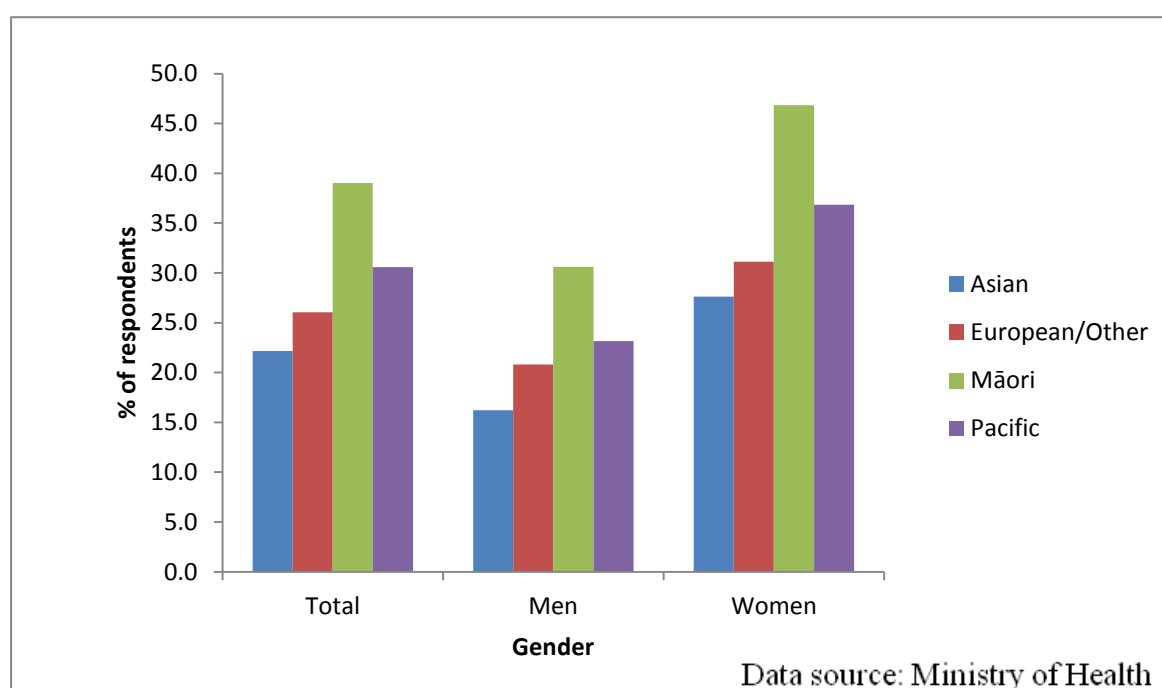


**Figure 5.1:** Difference between survey years of percentage of respondents by ethnic group who visited a GP in the previous 12 months prior to the survey.

### *Unmet need*

Unmet need is defined as being unable to get an appointment at a usual practitioner within 24 hours or being unable to see a practitioner due to cost and/or lack of transport at any time. Of the four major ethnic groups within the 2011/12 health survey the Asian population were the least likely to report experiencing unmet need in accessing primary care in the previous 12 months prior to the health survey being taken (Figure 5.2). This was the situation for the Asian group as a whole (22.2%), but Asian men (16.2%) were significantly less likely to report any unmet need for primary care than Asian Women (27.6%). This difference between genders equated to those gender differences for all ethnic groups. The Māori ethnic group (39%) was the ethnicity to most likely report unmet need for primary care, followed by Pacific (30.6%) and European/Other (26.1%). However, these proportions of ethnicities likely to report unmet need are a sharp increase from the proportion of each

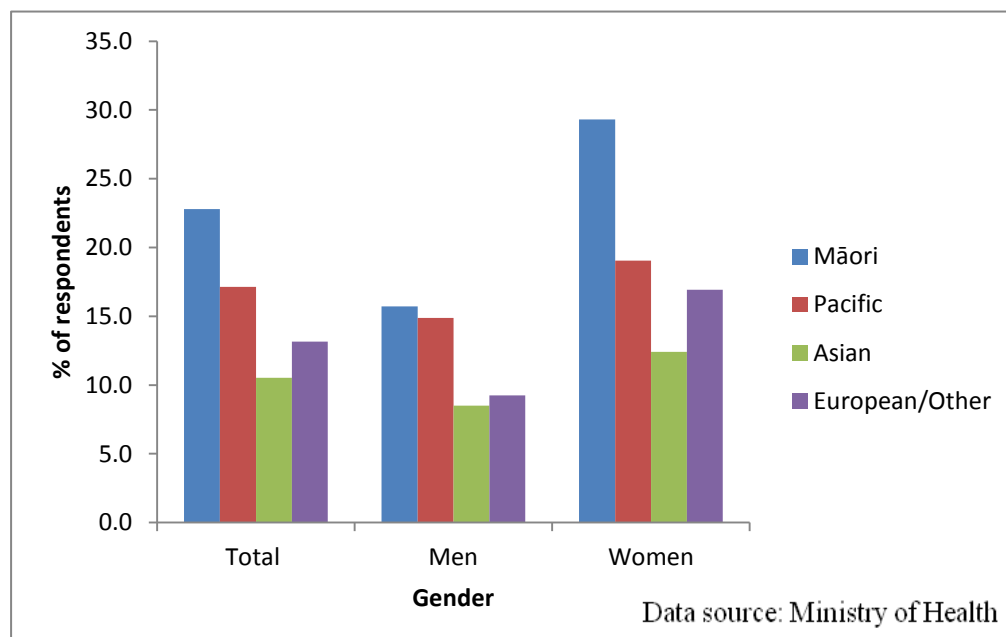
ethnicity likely to report such in 2006/07. The change would appear to correspond to the decline in GP utilisation shown in Figure 5.1 above. In the 2011/12 New Zealand Health survey Asian women were much more likely than men to have visited a GP in the previous 12 months prior to the survey. The pattern of unmet need was the same in the 2006/07 and 2002/03 surveys. The difference between the genders may in some part be attributable to pregnancy and associated health care needs. However, of import is the significant decrease between the 2006/07 and 2011/12 surveys in the number of men reporting they had seen a GP in the previous 12 months prior to each survey (71.6% to 68.8%), whereas those Asian women seeing a GP had slightly increased from 74.8% in 2006/07 to 75.9% in 2011/12.



**Figure 5.2:** Percentage of respondents who experienced unmet need for primary care in the past 12 months by ethnicity, 2011/12

Cost remained an important factor as a barrier creating unmet need for Māori and to a lesser extent the Pacific ethnic group, but not for Asians (Figure 5.3). The Asian ethnic group were the least likely to report cost as a reason for unmet need for GP services at 10.5%,

whereas, Māori were the most likely to report cost at a cause of unmet need for a GP at almost a quarter of the ethnic group at 22.8% with Pacific and European/other at 17.1% and 13.2% respectively. Thus, the difference between ethnicities in regards to this cost factor is likely to have an important role in influencing particular groups to visit a GP. That Asian people are least likely to report cost as a reason for unmet need may be related to cultural reluctance to report low economic status. Moreover, as indicated in Chapter 3, not all Asian people are wealthy and many are amongst some of the lowest income earners in New Zealand. Thus, there is an indication of an issue around culture as to how the question on unmet need due to cost in the National Health Survey is asked and answered by the Asian community. Law et al. (2005) have written on the issues with questions asking about unmet need in terms of understanding as to the wording of questions are phrased to cultural groups. A greater awareness of cultural understanding towards how cultures may respond to certain questions, along with a level of flexibility in rewording/rephrasing questions to suit the cultures, may be required by the survey interviewers.



**Figure 5.3:** The percentage those reporting unmet need for GP services in the previous 12 months due to cost, 2011/12.



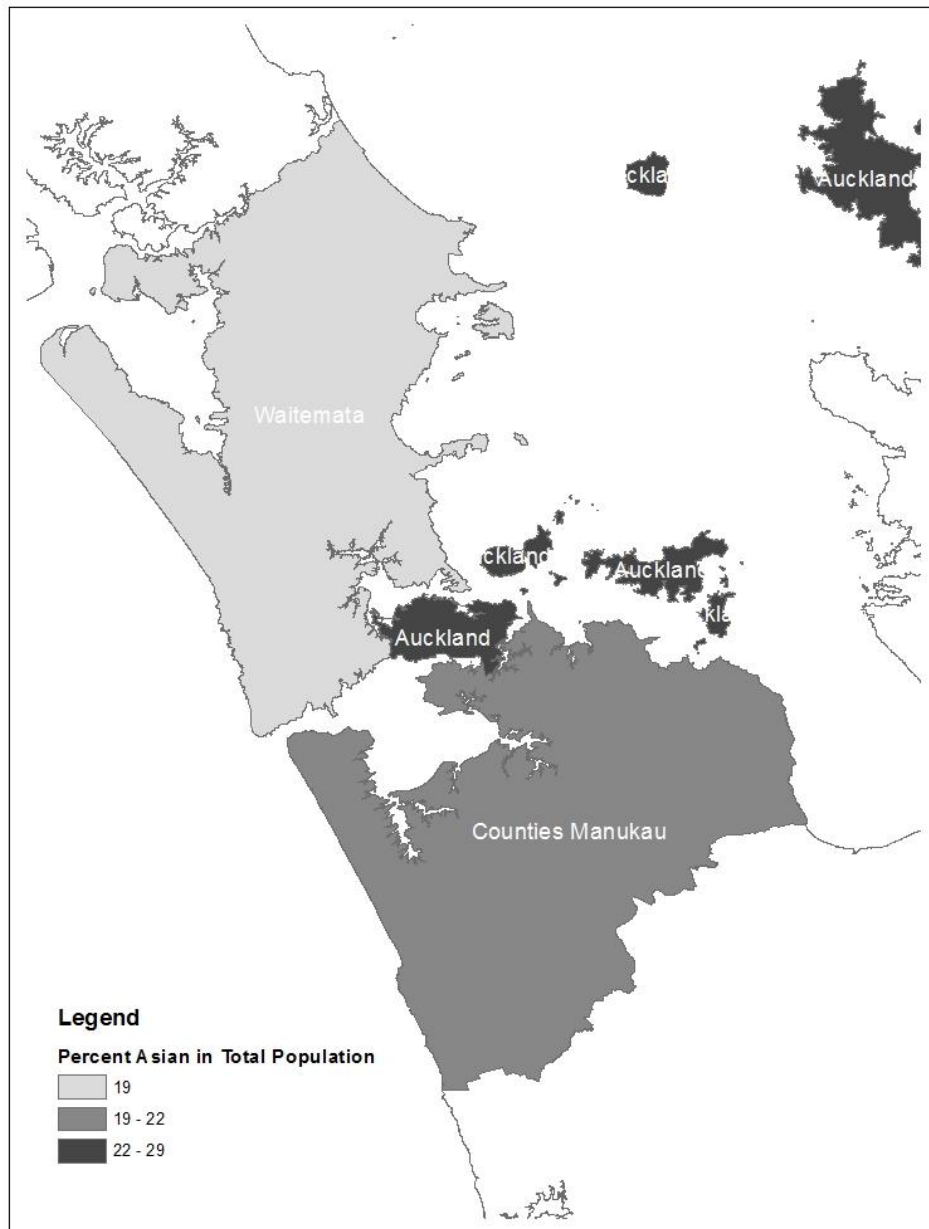
The percent of Asian people enrolled with a GP appears to be similar to the total Asian population within each DHB area, though inconsistencies in enrolment data confuse the accuracy of enrolment figures. Utilisation of GPs has decreased for all ethnicities in recent years, with Asian people being the least likely to have visited a doctor within 12 months. Similarly, unmet need has increased for all ethnic groups in New Zealand with the Asian community also being the least likely to report any unmet need including through cost. However, with Asian people being amongst some of the lowest income earners in New Zealand, the accuracy of the survey in terms of self-reporting unmet need remains somewhat questionable. Inaccuracies in reporting of need will influence how the public health sector responds to that need and to where and whom services are targeted. Thus, with potential inaccuracies in recording and reporting in place, investigation into the views and responses by the health sector on Asian health needs remains justified.

### **5.3 Response of the public health sector to Asian health needs**

This section reports on the response of the health sector and its provision of services towards the health care needs of the Asian population. The objectives of this section are to ascertain the response to Asian health care needs from the perspective of the DHBs and PHOs. A series of interviews were conducted with key representatives within one Auckland area DHB, three Auckland PHOs and two Christchurch PHOs to examine three issues: health services directed towards Asians, language translation/interpreting services and members of parliament views on health planning. Key people interviewed included chief executives, and health promotion and mental health coordinators in the two cities.

### ***Health services directed toward Asians***

Much of the response towards the Asian population and its health needs has been within the greater Auckland region. This is not surprising given the greater proportion of Asian migrants settling in Auckland city. The wider Auckland city/region has three DHBs: Auckland DHB, Waitemata DHB and Counties Manukau DHB (Figure 5.4). These DHBs provide health care management with the Waitamata DHB (WDHB) being the most prominent provider of health services directed at Asian health needs in New Zealand. The WDHB offers a number of services including an Asian Patient Support Service with Chinese and Korean cultural support workers, and within the support service WDHB also operate Asian mental health cultural support coordination services. While providing support to all Asian ethnicities, many of the services provided by the AHSS are aimed at the Korean and Chinese populations, reflected by the staff composition. This is in part not surprising given that these ethnicities are the two largest sub-groups of the wider Asian community within the WDHB.



**Figure 5.4:** Map of Auckland DHBs (Auckland DHB, Counties Manukau DHB and Waitemata DHB) and percent of Asian population.

The DHBs level of response towards the Asian population was in proportion to the required needs of the Asian population. A representative from an Auckland DHB (DH67) indicated the Asian population being at the “healthy end of the health spectrum [and] Asian people are clearly at lower risk” in every indicator and health services. As a result health services are not always targeted directly at the Asian population. In addition to the views of

this DHB representative, PHO representatives indicated that services were not always directed specifically at the Asian community, but that Asians were often covered by other health criteria such, as gender or age, and were “picked up through these means” (DH67).

Despite the similarity in funding of services towards the Asian population as a whole, services are targeted towards the South Asian population. One PHO representative (PH1A) in the Auckland area stated services are “geared toward the South Asian” population in terms of how the services are funded. South Asian health needs are similar to the health needs of Māori and Pacific populations. Similarity in health needs includes high prevalence of cardiovascular disease, diabetes and associated health indicators such as obesity stemming from more sedentary lifestyles after migration. This PHO provides for a “South Asian lifestyle coordinator” to promote culturally appropriate health promotion activities towards reducing the rates of diabetes and heart disease prevalent among South Asians. These activities include nutrition advice and “bollyrobix an aerobics class set to Bollywood music” and a Muslim women’s swimming programme where a public pool in Mt. Roskill is closed to the general public allowing Muslim woman to learn to swim in a culturally safe environment.

In Christchurch targeting of services towards the South Asian population is repeated. A PHO representative (PH9C) explaining the “Well Men’s [and] Well Women’s Checks programme we run” are targeted at those South Asians over 35 years of age (as for Māori and Pacific), whereas these checks are otherwise for those over 45 years of age including other Asian ethnicities. This targeting of the South Asian population represents a response to where health needs are most warranted within the wider Asian ethnic group and is equal across regions nationally despite different sizes of local populations.

Understanding of Asian health needs have not always been understood. In response to the increasing number of Asian migrants one Auckland PHO indicated at the time of the PHOs creation the PHO “understood the health needs of Europeans very well, but large

numbers of Asians were enrolling and we did not understand what they thought about health” and “if they were to tell us what their greatest health needs were, would they match ours?” (PH3A). To better understand the health needs of this increasing population the PHO ran a number of focus-groups “led by Asian members”. The outcome of these focus groups was “good”, learning that the participants’ of the focus groups “understanding of the health system was good”.

In Christchurch, consultation with the Asian community to identify needs of the population has been undertaken by the Asian and Migrant Health Advisory Group which works to give advice on ways to improve health outcomes for Asians and migrants. Currently, this group is focused on increasing the utilisation of cervical screening by the Asian ethnic group and smoking cessation. The latter is a national health target set by the Ministry of Health, so in part reflects requirements set in place at a national level.

### ***Language translation/interpreting services***

Language has long been recognized as a key barrier to the utilisation of health care and is essential for the access and quality of health care services. In New Zealand, trained interpreter services are provided by various organisations including down to the PHO level. The Health and Disabilities’ Commissioner’s (Code of Health and Disability Services Consumer Rights) Regulations 1996 state that an interpreter must be provided when a patient has no or a limited command of English, when there is a concern that the patient does not understand the clinical information, when the patient is deaf and understands sign language, and when family are consulted regarding the patient’s treatment and they need an interpreter to help communicate.

Language assistance to migrants has been extensively provided in New Zealand at both a national and regional level. At the national level the Ministry of Ethnic Affairs funds Language Line. These services are provided free and include telephone and face-to-face

services through Language Line (a nationally based service over the telephone), DHB based interpreting services. Those health providers interviewed in the Auckland area pointed to the Waitemata Auckland Translation and Interpreting Services (WATIS). While a service of the WDHB, WATIS provides translation services across the wider Auckland region. All of these services provide access to professionally trained interpreters and translators with these services being available to DHBs as well as primary care services, government and non-government agencies from various sectors.

In the Canterbury region similar language services are provided to PHOs through the nationally based Language Line and through the local Interpreting Canterbury, which is a telephone and/or face-to-face service, at no cost to the practitioners or patients. A PHO representative (PH3C) from a Christchurch based PHO reported use of these services were low as it is elsewhere in New Zealand. The reasons for the low use of interpreter services were said to be, in part, from a lack of knowledge of the services being available, but mainly due to the practicalities of using the service in a busy GP clinic. The barriers to use of interpreter services are discussed further in section 5.4.1.

### ***Members of Parliament Views on planning for Asian peoples' health needs***

Telephone interviews were carried out with four Members of Parliament from the centre-left Labour Party<sup>10</sup>. Members of Parliament, stated during the telephone interviews, in relation to the planning needs in response to the increasing demands posed by the Asian ethnic group that further analysis was required around the Asian ethnic group. This is required for a number of purposes including: for the better informing for the location of culturally specific services “which PHOs are better able to do”, what “actual physical plant” (medical equipment) is required and knowing “who is your staff” (ethnicity and qualification

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<sup>10</sup> Members of Parliament from the centre-right National Party were contacted, but none responded with interest in participating in the study. The National Party was in power at the time the study was carried out.

level) for that location (MOP23, MOP35). MPs pointed to the need to “match [a medical] centre itself to the nature of the population” within a community or neighbourhood and for the GPs and nurses to have “knowledge of [the] people they are treating” and to be “culturally aware”. The health sector needs to “develop the expertise to understand the migrant experience” (MOP23). A means to this was suggested by another MP (MOP46) to utilise those overseas trained health professionals who otherwise are unable to become licensed to practice in New Zealand, for reasons such as language. It was not suggested that regulations be relaxed for these people, but ways to better utilise this resource within the Asian and other migrant communities should be found.

MPs also indicated that it was also important for the Asian migrants themselves to be informed of what is available in New Zealand in terms of health care services. Within the knowledge of health services migrants need to be simply aware there is a health care system available, which they “can use as [the patient] needs it” and “knowing it’s there” (MOP23). In addition, migrants need to be made aware as to what kinds of services are available at a particular place not simply that a clinic exists, “who is there, doctor nurse speaks Japanese for example. Knowledge of this stuff will help migrants to utilise” the health care available. Migrants need to know it is culturally safe to go to a clinic; that “they will be understood culturally”. The migrants need “confidence that it will be alright to visit there” (MOP35). This understanding is important as some cultures are “shy” in regards to age and gender related issues (e.g. “incontinuity, bowel movements, genderual health”). In relation to gender issues, MOP23 also suggested migrants also need to know about, and thus need to be informed about, practices in New Zealand, for example “breast and bottle feeding” and the “expectations of Plunket”. To meet the needs in having a well informed Asian migrant population “settlement services need to be improved. For example, a community to which

refugees are moving to may be unaware that they are coming, and thus a “better welcoming solution is required” (MOP23).

The New Zealand Parliament’s undertaking towards Asian people’s health needs have been limited in that Asian health concerns have not been raised as part of the work of the Parliamentary Select Committee for Health. One former member of the committee (MOP52) indicated during her term on the committee “our Health Committee has not had any consideration of specific Asian health issues”. Communication with the committee reported that after a search of the committee proceedings back to “1997... the Health Committee has not had any business which considered Asian health needs” (Committee secretary, pers. comm., 2013). A response that indicates Asian health needs are low on the political agenda in New Zealand.

#### **5.4 Views of health professionals on Asian utilisation of health care**

The objectives of this section are to gauge from health professionals and those working closely with patients the key aspects of Asian health of concern to health professionals, and their reactions to Asian health practices in New Zealand. As indicated in Chapter 4, to meet these objectives interviews were carried out with General Practitioners and General Practice Nurses in Auckland and Christchurch. Three of the five professionals interviewed had been trained in New Zealand, while the two others were a UK trained nurse and GP. In addition, a series of interviews were conducted with key representatives within three Auckland PHOs and two Christchurch PHOs. Key people interviewed within the PHOs included chief executives, health promotion coordinators and mental health coordinators in the two cities. Three key issues identified during interviews were around the health care utilisation by Asian patients, the philosophy or practice of care and issues with medical staff.



### ***Health care utilisation by Asian patients***

Unsurprisingly, all the medical practitioners interviewed noted their patients came to their clinics because there were ethnically concordant doctors available. This may be desired for reasons of language commonality or for reasons of comfort, and being able to deal with someone of their own culture. However, one practice nurse explained patients often “don’t come until they are very sick or they go to ED as a first point of contact” (MP5C).

Three of the health practitioners interviewed indicated the necessity to educate patients on the health system in New Zealand. They also noted the frustration frequently shown by Asian patients at needing to see a GP before being able to get a referral to see a specialist and for a first assessment by a GP. As one nurse explained, “They become frustrated with the wait, because in China or some other Asian countries they can go straight to see the specialist” (MP5C). A nurse in Christchurch expanded further “They will choose not to get any treatment, or will go to ED as it’s instant if it’s serious enough” (MP9C). The reasons for going to ED in the first instance were explained “because [in Asia they] don’t have the GP system. They can just go to either without the GP referral. That’s why many Asians here just go emergency room” (AH01C). Thus, for many patients there is a system barrier raised by the need to consult with the GP in the first instance of care which patients will attempt to circumvent.

Health practitioners and promoters pointed out that education and time to explain the health system to patients was needed not only when they came into clinics, but also in the community. The need to educate stems from a lack of system understanding amongst patients who have come from places with different health care systems. This education requires an explanation of how the health system works in New Zealand. “We have to explain why they need to enrol with a GP, and why only one, and if they go to another GP casually not to enrol and we have to explain how the funding works” (MP5C). “I spend much of my time with

patients when they first come explaining how to access emergency care, and about the GP system, there is no GP in Japan” (MP8A). It was reinforced that there was a need to take the time to educate Asian patients on New Zealand modes of health care. A nurse explained that for the medical and reception staff having to explain the systems was not a problem, but “from the patient’s point of view it can seem very complicated, from their point of view why not make it simpler”. Both the GPs and nurses stated once they had explained to their patients why and how health care operated in New Zealand the patients were happy and continued to use local health services. However, it must be noted this education by medical staff was carried out in the patient’s language or from someone of similar culture, easing the explanation.

### *Philosophy of care*

A common reported issue about Asian patients, by PHO representatives and health practitioners, was the perceived expectations held by migrants towards health care provision in New Zealand and outcomes from a visit to the doctor. Conflict can arise around the expectations of migrants and the differing philosophies of care and of medicine that exist between the migrant’s country of origin and New Zealand.

During interviews practitioners made the point that Asian patients frequently make requests for a pharmaceutical solution for often minor ailments which can be somewhat of an issue. An example given by three practitioners was the expectation to receive antibiotics for minor illnesses such as colds. One GP explained Japanese patients “loved to get something”, to be prescribed something (MP8A). However, the GP indicated that there has been a shift away from the prescribing of antibiotics in New Zealand and, in fact, that in medical school it had been taught it was best to explain to the patient that “when you don’t need something, it is best not to have it” (MP8A). Antibiotics may well be useless and could create side effects

that would then require additional treatment. This final point is frequently a feature of prescriptions in Japan with a patient receiving additional medicines to treat the stomach's reaction to the antibiotic.

An example of a request for a diagnostic procedure from Japanese patients is for a Barium Meal test. The Barium Meal test is readily available and commonly used in Japan but such tests have all but disappeared in New Zealand. While not immediately dangerous to a patient, one GP voiced concern over the repeated requests for use of this test by patients from Japan where the Barium Meal is still a common and frequent test. "I referred one patient to the specialist after constant requests from him, and the specialist told that [him/her] was not in the best interests of the [them] have the test". Once this was explained to the patient, the reasons behind not using the test and the recommendation of the specialist, the patient understood and was happy with the level of care.

A Christchurch GP (MP7C) commented that Asian patients want everything that is available, particularly when there was no associated cost for the patient to access these services. The example the GP gave was for blood tests where the cost is "picked up by the DHB". Knowing that the tests are free for the patient to have carried out many Asian patients say; "I had last month, can I do it again". And talking of all his enrolled patients "it's not that 'New Zealand' patients don't want it, just that Asian patients want more, especially when they don't have to pay for it". Thus, some Asian patients are not necessarily under-utilising health care in New Zealand, but are attempting to over-utilise the various modes of health care available through a GP. The GP explained he had to act as "a gatekeeper" to these services, declining to extend, as in the example given, blood tests upon the request for a repeat from a patient. How this denial of service affects the patient's later utilisation of health care raises questions that cannot be completely answered without consulting the individual patient.

Health care practitioners also commented on the differences in care practice desired by Asian patients based on what they had been able to receive in their home countries which influenced their perceptions towards health care in New Zealand. For example, one GP received many requests from Japanese patients for an IV during consultations for such illnesses as influenza, because this is a common rehydration treatment in Japan. This use of such pharmaceuticals was also spoken of by a practice nurse, “In some Asian countries IV fluids, antibiotics or other supplements are used often...” (MP5C). The GP noted it is “generally better to orally hydrate and anything that avoids pain for children is probably best” (MP8A). It was noted by the GP that for Japanese parents with small children this can be troubling, having to just watch their children get better without being able to give them something. This required much explanation from the GP to reassure the patient. The patients are “very keen to learn”, but the philosophy over pharmaceuticals is very different and education towards Japanese patients about medicine is a challenge (MP8A). The GP explained primary care in New Zealand tries to practice a lot of educational and preventative medicine.

A common idea put forward by the health practitioners was in connection to the educational and preventative aspects of health management central to primary care in New Zealand. These aspects were reported to be exacerbated by a patient’s intended length of stay in New Zealand. Many patients may only be in New Zealand for a short period of time, frequently only for a number of months such as students, and will visit a doctor if they have a cold. In New Zealand primary health care there is now an environment of more self-management and treatment of long term care of acute or chronic conditions. The short nature of a patient’s time in New Zealand may negate the ability of GPs to treat or to give follow up treatment if required. For many Asians with an expectation of a pharmaceutical solution not

receiving a prescription from a doctor can cause conflict towards the New Zealand health care philosophy and a perception of inadequate care received.

### ***Medical staff***

Also noted by some of those interviewed, both medical staff and PHO representatives (PN4C, MP5C) was the role of nursing staff perceived by patients. Specifically these perceptions are around the roles of nursing in New Zealand. “For some patients understanding of nurses’ role in New Zealand, in some Asian countries nurses are just seen as the doctor’s helper”, “but often patients don’t know who the nurses are; we wear different uniforms, and not always the same, and sometimes there is a male nurse” (MP5C). For many of the patients the nurse is seen as not a fully qualified health practitioner in their own right (PN4C, PH6A). The attitudes held by patients to the roles of staff in a medical centre can also become questioned by many Asian patients. It was reported during interviews that Asian patients often question why they need to see a nurse. Though, in other cases “they don’t always care who they see, as long as they can see a medical staff”.

However, it was also pointed out for some patients who are not totally aware of the fee requirements there was confusion over payments. “For some patients it’s do I have to pay double to see both” (MP5C). For one PHO the belief is in terms of the treatment of long term care and management that in most cases the nurse is able to perform a better job and in turn the doctor can concentrate on diagnosis and the initiation of treatment.

#### ***5.4.1 Barriers to health care***

Health professionals and those involved in the delivery of health care expressed views on certain barriers found to be influencing health care access and levels of utilisation of

the Asian population in New Zealand. The barriers explored here are language, translated materials, distance, and rights.

### ***Language and communication***

Interpreter services have tended to be poorly utilised by any ethnicity at the primary care level, differing from that in hospitals where utilisation is higher (Seers et al., Forthcoming). PHOs representatives indicated during interviews that they are investigating why this may be the case, and it was proposed by PHOs both in Auckland and Christchurch that practitioners may forget about the service and thus do not promote it to patients. Further, it was reported by practitioners the utilisation of the service needs to be well organised in advance in order for the service to work successfully. For example, if a patient is going to see a specialist a booking needs to be made three weeks in advance of the consultation allowing plenty of time to coordinate the interpreter with the specialist consultation. The interpreting service booking made for the consultation will be for an hour. In contrast, GP use is much more immediate, as often appointments are made for within 24 hours. It takes time to arrange for the interpreter, even for one over the phone, and GP clinics are “more chaotic” than time allows limiting opportunities for the service to be used in a GP clinic successfully (PH6A).

This belief differs to the thoughts and experiences of a practice nurse in Christchurch. The nurse stated Language Line was useful, but did not use a lot. This was mainly due to the nature of the clinic having a half Asian enrolment and half the staff being able to speak a Chinese language or Korean. However, it was used for other languages, other than Chinese, by some of the medical staff. The nurse believed this was because of having a high non-English speaking enrolled population, so the clinic was more aware of the services available. One nurse commented that frequently despite a good grasp of English, patients may prefer to

see and wait for an ethnically concordant doctor, for reasons of language and cultural comfort. The nurse also posited there is no reason for this to be the case.

Many Chinese have good English, but still ask for a Chinese doctor, as they feel more comfortable. Sometimes they will wait for the doctor to come back from two weeks leave. They are happy with their own confidence with medical jargon. But, we don't use medical terms, it's our job to explain, so we shouldn't use [medical jargon] (MP5C).

Medical staff need to understand the language abilities, or limitations and adapt their own language in explanations to suit the patient's capabilities.

In a more negative light on Asian patients, one GP (MP7C) told of how translation services can be used by patients unnecessarily to a level where use appears to be abuse of the system. "Some more well off Korean patients, some with good English, will want a translator, to get more service". This occurrence is happening because the patients know there is no cost for them to access the service and try to maximize the health provision towards themselves. The GP explained the translation service still needs to be paid for by "you and me, this money could go to better places or needs".

### ***Translated materials***

As described above, it was reported translated materials are available in a number of languages, examples being pamphlets for cervical screening, information on breast feeding or for influenza. One PHO representative interviewed indicated there were materials from the PHO available about enrolment, "on the website", and in printed hardcopy form at the practices in some Asian languages, but the representative was unsure which specific languages materials were available in. It was reported during an interview that the MOH and DHB are "loath to help" with translation of materials (PH6A). In addition it was pointed out

that resource material such as a pamphlet “if it’s in English it’s no use to us, don’t give it to us. It will just sit on a shelf” (PH6A).

Though it was reported by medical staff not all the materials required were easily obtainable in the desired language. One ethnically Asian doctor reported carrying out translations herself as she was not able to get translated material in the language needed for her patients.

I often translate something [as] I think is important for my patients myself.

It’s not always easy, I can speak [the language] well enough, but my writing is not always the best it could be, so it takes time.

A problem voiced by one PHO was the access to translated materials and their dissemination to the wider community. Multiple organisations produce translated materials related to health care and other health services, but these materials could also be of benefit to other organisations. Often the materials produced by one organisation are not always available to another, or these materials are unknown of outside of the organisation that produced them. Further, it was intimated by one PHO in relation to this material production there may also be a waste of funding that is “not always easy to get for this type of thing” (PH6A). While there is no single clearing house of translated materials that can be accessed by the various agencies and organisations that work with migrant and refugee populations in New Zealand, the Auckland based PHOs all pointed to “TANI”<sup>11</sup> as a good source of linked information. However, TANI is non-public initiative that bridges the gap between the public health sector and Asian communities, created after connections between the two groups were found to be lacking.

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<sup>11</sup> TANI – The Asian Network Incorporated.



### ***Distance***

One ethnically Asian doctor pointed out that many of her patients travelled far from outside the immediate area of the clinic at which she was based. This was primarily because the doctor was the only available GP in that ethnic group in the wider Auckland area, and indeed in the country. The GP's patients desired accessing health care in their own language and would travel some distance to be able to do so.

### ***Rights***

An Asian health promoter spoke of a lack of awareness of their rights to health care amongst Asian migrants, with this awareness being around rights to health care after an accident in the workplace. "Sometimes they get hurt at their work place, and the owner says 'oh, you have to treat yourself', which is totally wrong and against the law" (AH1C). The health promoter said this more frequently happened with those people in New Zealand for shorter time periods such as being on a working holiday visa. Everyone in New Zealand is eligible for injury cover under ACC, including those on work visas where otherwise they are ineligible for public health services.

#### ***5.4.2 Health interventions and screening***

The PHOs and health practitioners were asked what areas of Asian health they saw as most important in terms of intervention. Each organisation had different concerns as a first priority, but important for all interviewed was the early detection of illness and long-term management. Mentioned as important by all interviewed were the concerns towards mental health.

## ***Mental Health***

There was consensus that there is considerable social and cultural stigma towards mental health amongst Asian people which made treatment problematic. Mental health is in “the closet” and “a not to be touched subject” (PH7A). This stigma influences their admittance of having a mental health issue in the first place and in turn being willing to seek mental health care. All of the PHOs consulted in this study had dedicated mental health services directed towards the enrolled population as a whole. These services are located in general practices and within the community. Indication was made that improvement in this area of health is improving as “more Asian [people] are coming through, if slowly, as we are getting the message out, education is in progress and people will come in”. In addition, progress was also made because “many more Asian doctors are coming in for training around this as well”. Thus indicating improvements in

During interviews one practice nurse voiced concern over “lots of demand” (unfilled need) and patients were not “open” and did not “agree to talk about it” and that this mind-set continued “even after having had diagnosis for depression” (MP5C). “They are not open and don’t agree to talk about it, they are not open to further assessment” (PN95C).

In addition, a nurse pointed out if the patients do decide to get help there are not a lot of options due to language. In Auckland, within one PHO it is best practice amongst the member GP clinics of the PHO to try to match up the Asian patient with a psychologist or councillor who speaks the same language or “at least looks like them” (PH6A). Being able to ethnically match patient with a mental health practitioner is perhaps easier given the larger population.

However, in Christchurch, while there are Chinese, Japanese and Korean speaking counsellors, the Christchurch Asian community is small and frequently patients will know the ethnically matched counsellors personally creating a reluctance to utilise. Moreover, the

nurse spoke of using translators for mental health care as not being an appropriate aid to mental health care delivery. “Mental health is complex and can’t always get meaning across with translators” (MP5C). The work on increasing utilisation of mental health services is a matter of education to overcome the social barriers around mental health for the Asian community. The education processes are slow to filter through and there was a consensus amongst those all interviewed there is a lack of awareness among Asian people about the mainstream and Asian-targeted mental health services that are available.

### ***Sexual health***

One PHO representative mentioned that during a ‘train-the trainers’ workshop for young Asian people (aged 18-24 years) the trainees were angry at being told how their cultural practices were regarded by the PHO. “Many view abortion as a form of contraception. And we have been attacked, told off for judging their cultural norm, so we had to unpack that and discuss it with them” (PH2A). Further, concern was raised by an Auckland PHO with a large Chinese student migrant population and these people’s use of the intrauterine device contraceptive (IUD). The PHO told of how the IUDs are inserted in China and are allowed to remain implanted for a long time over which time they become embedded and difficult to remove. “They are desperate to have another child when they come to New Zealand and they [IUD] have to come out” (PH2A). Within the PHO a number of GPs are reported to be very experienced with their removal, but in some cases patients need to be referred to hospital for the IUDs removal.

One PHO reported presumed gender health amongst the Chinese student population in Auckland was not as serious as originally thought after carrying out a pilot study named the STI Clinic Screen and Treat Program in conjunction with the University of Auckland Health Centre. Everybody coming to the health centre was asked to participate and “involved a self-

swab for females and pee-in-a-pot for males, the treatment for Chlamydia is three antibiotic [tablets taken over three days] and you're cured" (PH6A). Assumptions had been made of the high prevalence of STIs, in this case Chlamydia, amongst the Asian student community stemming from these people "being away from home for the first time, flatting and thus in a high risk environment" for sexual activity. Results of the study showed an unexpected prevalence of only 3% for Asians, 12.8% for New Zealand European and 27% and 30% for Maori and Pacific respectively, the national rate is 11%. This study indicated that Asian students in Auckland were either practicing safe gender or abstaining.

### ***Cervical Screening***

In addition to sexual health, cervical screening was also reported as being of concern to health organisations. Cervical screening is a free service provided by the National Cervical Screening Programme to all women between the ages of 20 and 70 years. Regular cervical smear tests are recommended for women every three years, if they have ever been gender active. All women who have ever been sexually active should have a smear test for cervical cancer. However, this raises issues for many cultures as it requires an admittance of sexual activity, and this has been reported to be particularly acute for South Asians. Some groups of women have higher rates of cervical cancer including Asian women.

One Auckland based PHO voiced concern over attitudes of North Asian patients to screening practices, both how those are performed overseas and of the low level of utilisation in New Zealand. Concern was voiced over the "disclosure of information" to patients overseas. The PHO representative explained that for China and surrounding countries there is a differing culture of information and disclosure from that practiced in New Zealand. Screening is done in these countries, but the results are not clearly articulated to the patient. An attitude of "no news is good news" permeates, but bad news may not be disclosed either. The screening is carried out, but there is a refusal to have the screening in New Zealand for

reasons that are not fully understood as yet. This practice of having the smear in their country of origin raises issues for all the PHOs consulted, both in Auckland and Christchurch, as Cervical Screening utilisation is a health target set by the Ministry of Health.

To increase uptake of screening services the Auckland PHO provides funding for the most socio-economically deprived areas, measured as Quintile 4 and 5 as it is believed this will catch the patients in question, every year over a two month period. This involves every woman who walks into a GP clinic will get a free smear. Asians who do not normally get a smear are a priority.

### ***Cardiovascular Disease***

As noted in the previous section (Section 4.1), males from the South Asian population are known to have more CDV and its co-morbidities, having the similar risk rates as for Māori and Pacific people. The primary prevention for CDV is a Risk Assessment carried out in GP clinics and for those clinics with people identified as being at high risk will be placed on Risk Management (Ministry of Health, 2008). Risk management measures will include advice on smoking cessation, Green Prescription<sup>12</sup>, dietary advice and a number of pharmaceutical solutions. In New Zealand funding to carry out risk assessment screening for CDV is provided by DHBs to PHOs for Māori and Pacific and those living in high deprivation areas from age 35, but otherwise for all other people testing begins from 45 years of age.

A number of PHOs reported they fund GPs to screen for heart disease among South Asian patients 10 years earlier as is done for Māori and Pacific Persons, which means in practical terms 35 years of age for men and 45 for women. For all other people screening will take place from 45 years of age. With this in mind services are targeted towards South Asians

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<sup>12</sup> A Green Prescription is a health professional's written advice to a patient to be physically active, as part of the patient's health management.

in terms of how CDV screening is funded by PHOs. Risk control and management is funded at the same formula for South Asians as for Māori and Pacific. For one Auckland based PHO (PH6A) with a large Asian population a “broad sweep” is made to the total population and “everyone gets covered”, but the PHO only gets direct funding for Māori and Pacific patients and must extend funding into the South Asian enrolled population. To help cover this shortfall in funding needs the PHO applies a flexible funding formula that covers everyone, because it is a health target set by the Ministry of Health.

### ***Diabetes***

Diabetes has been reported as being of concern amongst the South Asian and Chinese migrant populations. A Christchurch practice nurse (MP3C) reported there was concern in their clinic for the increased prevalence of diabetes among their Chinese patients. The nurse told how the clinic worked hard to screen for diabetes, but many patients do not know they are diabetic;

...many of the patients find they have symptoms for diabetes after they have  
the medical exam for immigration which has the Hb1C as part of it.

Asian migrants are less likely to engage in healthy activities such as physical activity, tend to be more sedentary and to consume recommended daily amounts of fruit and vegetables. Lifestyle practices may be from acculturation or waning of migrant selection pressures effects leading to diabetes indicators such as increased prevalence of obesity and being a smoker. It was also reported Asian mothers were also susceptible to gestational diabetes with particular concern being voiced over gestational diabetes amongst young Chinese women, but many who voiced this indicated the reasons for the health concern were as yet unknown.

### ***5.4.3 Responses in Place***

During interviews health professionals expressed opinions towards the means to which Asian patients will seek out health care away from mainstream health care provision in New Zealand. These responses included utilisation of alternate medicine and returning ‘home’ for health care.

#### ***Views on patient’s use of alternative medicine***

A common subject matter reported by PHOs and health practitioners (PH3A, PH6A, MP5C, and MP7C) was the increase in alternative health practices being utilised by the Asian community. An Auckland PHO felt that it was now more common to find traditional practitioners in the community than in the past believing that “there are pockets of practitioners in various areas of the community” (PH3A). While acupuncture has long been an accepted form of medicine in New Zealand, traditional herbal medicines have been less accepted and perhaps less understood by the mainstream medical and wider community. A regular feature of the Chinese community in New Zealand is to utilise traditional herbal medicine. This health care resource/solution can be accessed in New Zealand through a number of specialist herbalists or through local stores stocking particular supplies of common products. “A lot of Asians, particularly Chinese” (MP7C) take the traditional Chinese herbal medicine. A GP with wide experience of treating Chinese patients suggested why Chinese may still continue to utilise this form of medicine in New Zealand as “they don’t trust the western doctor”. Indeed, the GP reported that in China itself if a patient is in a “Western Hospital and you’re not getting anywhere, book yourself out and check into a traditional Chinese medicine hospital”. For many Chinese the two systems function side by side as two separate systems.

The position of the mainstream health care sector in New Zealand on this form of health care was mixed amongst those interviewed. One PHO representative (PH3A) posited that “many of the GPs are Chinese so have a good understanding how herbal medicine interacts with western” [types of care]. However, such understandings are disputed by the Chinese ethnic doctors themselves. An ethnically Chinese, but New Zealand born and trained, GP in Christchurch (MP7C) stated that he had “faith in it, but I’m not trained in it”. By not having the knowledge that being trained in herbal medicine would bring the GP “usually ask [the patients] to stop what they are taking”. Herbal medicine and “orthodox” medicine can interact if taken together, so “you have to stop one”. This knowledge towards traditional Chinese herbal medicine was reinforced by a practice nurse in a medical centre with a high Chinese enrolment and concordant medical staff who pointed out there are frequently some problems with patients having taken herbal medicine and then visiting the medical centre for additional treatment.

Patients sometimes have a condition and it’s the herbal medicine which caused the symptom. The problem is we don’t know what they have taken, and we are not always sure of the reaction between the herbal and the western and the side effects of herbal, so we can’t be sure the symptom is caused by the herbal (MP5C).

This lack of knowledge, while no fault of the medical staff, is to “have to convince the patient to a break from the herbal” (MP5C). While evident the health practitioners have no problem with traditional herbal medicine, effort is needed to work with patients using such medicine to better manage their health care. Effort is needed in terms of assisting the patient to utilise either mainstream or traditional medicines, but not both concurrently.



### *Views on patients' returning 'home' for health care*

A large number of Asian residents have indicated that they return to their countries of origin to seek health care. This phenomenon was asked about during interviews with the health care professionals so as to understand concerns that may be held by the health sector around this phenomenon. Of the four primary health care practitioners interviewed there was a mixed opinion on those who returned home for health care. For example, one GP expressed concern over this in relation to when a patient had undertaken a medical check-up in the patient's own country of origin, but had returned to New Zealand for the actual medical care. Of concern was where a series of x-rays had been taken, but the prints had not come to New Zealand requiring a further series of x-rays. This doubling of x-rays increases the risk of over exposure to harmful radiation, exceeding the yearly dose limits. Conversely, a second GP expressed no concern with this, explaining that the x-rays would be required anyway.

A number of issues were also reported with the bringing of medical reports after a return home for health care. One point raised with these reports was that they were always in the language of the patient. There often were also reports from a specialist requiring further consultation by the GP with a New Zealand specialist in the same area of expertise. This requires translation of the report adding to the work required and delaying the care of the patient. For the clinic this was fine if in one of the languages spoken by staff in the clinic. "If it's in Chinese or Korean it's okay, but in another language we have to get it translated" (PM5C). In contrast, a GP (MP7C) with a high Chinese and Korean patient enrolment (20% of total enrolment at the clinic) stated he had little problem with the reports coming back with patients who had had tests done overseas, but "as long as it's in English". Patients returning with reports on the tests done overseas "mean I don't have to do something" (MP7C). Often the patients are recommended by the overseas doctor to seek treatment from their New

Zealand doctor when they get back due to the time constraints of a visit and are told “to do something about it”. For the GP “that doesn’t bother me”.

An additional issue needing to be contended with raised by a GP about returning patients with reports was with the types of tests done in the country of origin that in New Zealand are not done within a GP clinic. These include tests such as x-rays and ultrasounds which are often available in not only the larger hospitals but also in smaller local medical clinics.

We have to send them to the hospital if they really want to have that test, but then they will have to wait for the hospital to come back to them. This is often why they go back because they will be able to get the test sooner (MP9C).

Along with these issues of the reports from overseas sought health care was the medication that may have been prescribed in the country of origin. The patients frequently bring in their prescription which may be available in New Zealand under a different brand as “there is usually an equivalent one here” (MP7C). Frequently the drug or medicine the patient has brought with them is available under a different brand name, but “this is no big deal for us, we just have to explain it’s the same drug, but comes under a different branding and the patients usually accept this very easily” (MP5C). However, not all drugs are available in the same manner between each country as...

...where issues arise [for the patient] is if the drug is not funded or is funded at special criteria and often it is cheaper overseas than in here, so we have to explain they can pay extra or offer to start over again (MP5C).

The adaptability of patients to accept medicines under differing levels of availability is important for their ongoing satisfaction with health care in New Zealand.

In addition to the medication from overseas, a factor also raised by health practitioners during interviews, was the treatment received while overseas. Some surgical procedures are more readily available overseas than they are in New Zealand and as a result knowledge amongst New Zealand GPs is not always complete requiring further consultation to be able to manage the patient's health. Knowledge of surgical procedures by GPs is important in terms of follow-up care required post-surgery as a number of the health professionals pointed out; "with surgery we have some idea what has been done to an extent, but it's not always the same procedure, so we are not completely sure about follow up" (PN9C).

We don't know exactly what they had done, but they come back and need a follow up. We sometimes need to refer to a specialist for follow up... the GP does not always have the knowledge, so they get advice from the specialist at the hospital (MP5C).

While the need to seek advice elsewhere may seem work producing within already busy clinics, it was seen to be simply an aspect of the health care provision for these patients.

## **5.4 Conclusion**

This chapter has presented the results from the analysis of secondary data relating to utilisation of primary health care in New Zealand and from analysis of interviews with representatives from PHOs and health practitioners. Enrolment rates with PHOs by Asians appear to be closely related to the Asian population of each DHB with little difference between the two. Despite the apparent high enrolment, the 2011/12 National Health Survey reported utilisation by Asians is low with those Asians having seen their usual practitioner in the previous 12 months was the lowest of any ethnic group in New Zealand, despite an

increase in visits since 2006/07. The Asian ethnic group is least likely to report unmet need for any reason, including cost, of any ethnic group in New Zealand. The low incidence of reporting of cost being an issue is at odds with Asian people being amongst some of the lowest income earners in New Zealand. Low reporting of unmet need due to cost may be a result of cultural reticence or stigma towards indicating low income or socio-economic status.

This chapter has uncovered a number of important themes in relation to the response to the health needs of the Asian migrant population in New Zealand. First, the response to Asian health needs has mostly been centred in the greater Auckland area as a consequence of the larger Asian population here. The response has included Asian oriented services and programmes designed to encourage services use and more healthy activities. In Christchurch PHOs do operate Asian oriented advisory groups. Second, from the interviews with health providers Asian utilisation of health care services is dependent on ongoing education about health care in New Zealand, reducing communication barriers such as language and health information. Work on reducing barriers also includes those of cultural expectations of health care, moving towards better understanding and acceptance of the philosophies behind health care in New Zealand. Third, the health sector's response to illness amongst Asian patients' was directed towards the immediate needs of identified at risk ethnic groups. Sub-Asian ethnic needs being addressed through national health care strategies that include earlier screening profiles and encouraging more healthy practices. Within the response to illness, the health sector was working to increase utilisation of health services, including mental and sexual health services, overcoming cultural barriers to such services. The following chapter explores the perceptions of Asian patients to the provision of health care in New Zealand and their reactions to that care.

## **Chapter 6 Perceptions of New Zealand health care by North Asian cultures**

### **6.1 Introduction**

This chapter presents the results of the analysis of the interviews of Asian participants. In so doing the chapter will respond to the research questions of how 'home country' health care experiences influence health care utilisation in a New Zealand, what extent perceptions and experiences of primary health care in New Zealand influence patterns of utilisation and how modes of acculturation influence utilisation of primary health care in New Zealand.

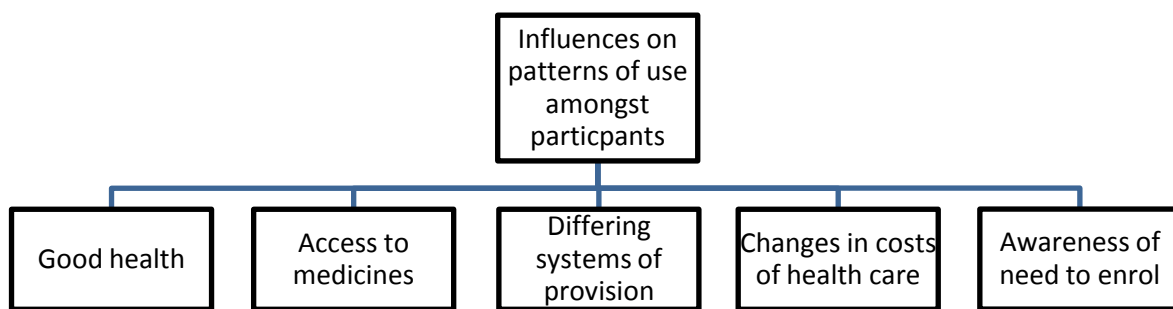
There were multiple themes identified in the interviews which influenced the perception and utilisation of health care. These are reflected in the structure of the chapter which is separated into four major thematic sections: patterns of health care use both in New Zealand and prior to migration; perceived barriers to health care in New Zealand; responses made by the participants to accessing health care in New Zealand; and, responses out of New Zealand. The themes are presented below with excerpts from the transcripts. The quotes throughout this chapter have been reported verbatim, with no correction of the English grammar.

Participation in this research was completely voluntary. 65 Asian participants were interviewed, but not all the participants' responses have been included in this chapter. Participants' identities have been safeguarded through random allocation of code numbers.

### **6.2 Influences on patterns of use amongst participants**

Past patterns of use in the participants' home-countries affected their use of health care in New Zealand in different ways. Figure 6.1 illustrates the themes of differences between countries that influenced use of health care. Health status was very prominent as

being a driver in patterns of use, both in terms of having good health, or not, before and after migrating. Continuing and changing health, frequently related to older age and reproductive health needs influenced to what extent participants accessed and utilised health care in New Zealand. Changes in how participants were able to access medicines, differing health systems (such as GPs as opposed to specialists in the first instance), changes in how health care is financed. The awareness of the need to enrol with a single GP was also lacking at times. Patterns of utilisation in New Zealand were influenced by past accessibility and use of health care flowing from one place into another after migration.



**Figure 6.1:** Reasons for changes in patterns of use amongst participants after migration

### ***Good Health Leading to Lower Utilisation in New Zealand***

For many of the participants there was little change between their former patterns of utilisation and post migration patterns of health care. In many cases the participants' patterns of use in their home countries stemmed from good health and little need to see a doctor relating to a perceived seriousness of illness, which in turn flowed into patterns of health care need and utilisation in New Zealand. Comments from participants were common across all three ethnicities; "sometimes, just cold, I am healthy" (C46), "in Japan hardly, maybe once every years or two years... (J2), "not often... I didn't go to the doctor for just a cold" (J49),

“I never saw the doctor in my whole life” (K16), “not often go to see doctor, just if I am sick, so if serious sick I can go see the doctor, if not I just buy some medicine and go home” (C22). The self-perceived healthiness of the participants frequently led to low utilisation of health care in New Zealand. Indeed, a common response of the participants stated they did not visit the doctor in this country because they were healthy. And as one Japanese man (J47), 14 years in New Zealand, put it: “if a Japanese or other Asian doesn’t go to the doctor, it’s not because they are less informed or less educated, it is because they are OK or healthy”. For this man the legal obligations associated with his employment prompted continued visits to his GP and were not directly health related. “Now I have a check every 5 years for my passenger service licence, it is an obligation”, but otherwise he said he was healthy and did not need to go to the doctor. Indeed, one Japanese woman (J2) who had been in New Zealand for 10 years only went to the doctor “about once a year, just hay fever”. One male Chinese participant (C9) reported he had only been to the doctor once in 10 years since coming to New Zealand. Moreover, his visit occurred only when his wife had prompted him to do so after cutting himself in the garden, “I think that was the first time to visit the GP; the only time in 10 years”. His infrequency of visits had actually prompted correspondence from his GP asking if he was still a patient at that clinic, which he laughed about.

Other participants spoke of how they went to the doctor more often in their countries of origin, but less so since migrating to New Zealand. Reasons for this change in utilisation pattern were numerous, but for many the change was not simply from not being as unwell as they had been previously. Some participants put this healthier result of living in New Zealand to decreased levels of stress. A woman from Taiwan (CT30), who had been in New Zealand for 7 years, said she went to the doctor in Taiwan:

...quite often, I remember I have to [go] every month, I have [a] stomach problem. Maybe the life is very pressure, my children [are] very young and

always the pressure. Nervous every day I have a stomach problem. I come here I don't have the problem, not happen, so much better.

For this woman, migration and life in New Zealand had had a positive effect upon her health status, which affected her utilisation patterns. She told of having gone to the doctor for some injuries sustained during gardening, but was otherwise in good health and did not need the doctor. However, a Japanese woman (J52), in New Zealand for 3 years, noted that “in Japan I used to go the doctor right away, often... maybe once in a month, every two months”. This woman had frequently visited her GP since coming to New Zealand. She told these visits had included immigration and then for reproductive health and child birth, but that she did not have a regular GP she was enrolled with.

For three of the interview participants a reason to visit a doctor in the country of origin was not related to any illness, but was associated to employment policy of sending employees for a check-up each year. These check-ups are free for the employee with the company paying any fees that may be associated with the health check-ups. An older Chinese woman spoke it was free for her to “go for check, I am teacher, so free”. A Japanese man (J56) went to the doctor “every year I had to go to the doctor for the check-up from my work. I don't know if the university paid, but it was free”. These employment associated visits to a doctor can increase health care utilisation patterns and are connected to good health, not out of needs associated with ill health. On a similar note, one Japanese woman (J74) spoke of her home town providing free health check-ups every year, “but our town was rich” and she was not sure which other towns provided such a service. Despite a desire for such health checks, without the easy availability of them each year in New Zealand participants did not to go to the doctor.



### ***Differences in access to medicines***

There are differences in the availability of medicines between countries. Certain medicines may only be available through a doctor provided prescription in one country, while the same medicine is available through a pharmacist in another country without consulting a doctor first. Some Korean participants also spoke of not only going to the doctor in Korea unless they were seriously ill, but also of not going to the doctor at all in the first instance. One Korean woman (K12), 15 years in New Zealand, told it was common practice “when we get sick we go to the pharmacist, and if they don’t work we go to the doctor”. In Korea pharmacists are able to prescribe medication that is otherwise only available with a prescription from a doctor in New Zealand. This differs somewhat from Japan where medications are much less available unless through a doctor. Moreover, such commonly available medications, such as paracetamol, obtainable from the supermarket in New Zealand are pharmacy only medications in Japan. “...so every medicine I discuss with the doctor, to make sure it is OK for me” and “over time I have come to know they are good and I have got used to the difference” (K12).

### ***Differing systems of health provision influencing utilisation***

It is possible to visit a clinic more easily on a casual basis within the participants’ countries of origin, differing from New Zealand where enrolment with a single GP is generally required in order to access health funding and reduced charges. The New Zealand system of enrolment tends to discourage casual visits at another GP clinic due to the extra fees attached to a casual visit. Further, in the participants’ home countries it is possible to access specialists in the first instance, as opposed to first needing a referral from a GP in New Zealand. A common feature of many of the Japanese and Korean participants and those participants from Taiwan (e.g. J02, J06, K12, K70, C24, CT19, CT8) was the practice of

going to different doctors each time they needed to see a doctor. “Different doctors every time”, “I went to different clinics, but they usually give pretty much the same advice or medication”. In some cases visiting a different doctor at each visit was as a result of local practices of going to a specialist in the first instance.

As one Japanese woman (J3) said “we don’t have a GP system in Japan, so sometimes I have to go to ear, nose throat specialist, sometimes I just have to go to the hospital”. And a Taiwanese woman (CT19) “...we have many specialists and we can go there if we want, if we have eye problem, eye doctor, even obstetrician and ear any kind of specialist we can go”. These participants spoke of needing to see the GP first as a hindrance, the “GP is not a specialist”, and a perceived barrier to good health care. This factor of difference between the participant’s countries of origin, none of which have a GP/family doctor style of first point of contact primary health care, and New Zealand that causes a less than positive perception of health care in New Zealand. This system of provision works to create a barrier to health care utilisation and will be discussed in more depth ahead in this chapter.

Two participants told of going to the same doctor each time, and did so because of the relationship they had created with the doctor. However, they told it was easy to go to another doctor if they were away from home. A Taiwanese woman (CT8), aged 51, told how:

...we used to go to the same doctor, but if you are far away, maybe in another place, you can find one nearby; you don’t have to travel [home] to go back to the same doctor. If it’s not an emergency you can go back.

When asked, the woman told there was no additional cost with seeing a doctor in another town, so it was very easy for her to visit wherever she happened to be at the time. Patients were able to ‘hunt around’ for a doctor they liked. This was also the case for a Japanese woman (J74) who, while in another part of Japan on holiday, took her son to see a doctor when he became sick. “We don’t pay extra, we have our health card, we show and pay the

same as back home”. The woman felt she could not do that in New Zealand as “you can’t just go to another doctor where you are, and it costs more”. These differences in accessibility between places, created barriers towards accessing health care in a timely manner, creating unmet need.

### ***Change in costs between countries influencing utilisation patterns***

Funding of health care differs between countries, as does the amount a patient contributes towards a visit to the doctor. A common reason voiced by participants for their high rate of health care utilisation in their home countries was the lower cost of visits to a doctor there. This low cost was frequently reported to the existence of social/public health insurance systems in the countries from which the participants had migrated from. In Taiwan one woman (K19) stated she went to the doctor “very often because in Taiwan all people have health insurance”. Another Japanese woman (J74) spoke of the doctor being cheaper and “we only pay thirty percent, because of insurance, sometimes like five dollars”. This low cost experience was carried into perceptions of New Zealand primary care as being expensive.

### ***Awareness of need for enrolment***

A number of the participants indicated they had not known they needed to have a GP despite having lived in New Zealand for some years. Participants indicated they only went after activities linked to everyday life in New Zealand informed them of enrolment requirements compelling them to seek enrolling with a GP. For two participants their children’s school asking about their child’s GP prompted them to find a GP. One, a Japanese woman aged 43 stated; “My daughter went to school and they asked who is your GP. And we thought ‘Oh we need a GP?’”. And the second, a Chinese man, aged 54, said; “my daughter go to high school, they say I need a GP, so I apply to a GP near there”. Otherwise they would have not gone to the doctor. One interview participant, a 67 year old Chinese man (C36), was

unsure whether he was enrolled or not after having visited a GP. “I am not sure. My daughter has a GP and went there for a blood test, but don’t know if I registered. My daughter has one”. This participant had not been in New Zealand for very long and his daughter, who had been in New Zealand for over 10 years, had taken him to the doctor for the blood test out of her own concerns over her father’s health, “but I was healthy, I don’t go again”.

An often mentioned reason to first visit a GP was for the medical tests required for permanent residence or another change in visa status. These tests involve extensive questioning and a chest X-ray and can be carried out by any doctor or radiologist in New Zealand. Thus, if the migration applicant is applying for a residency or work visa in New Zealand they will come into contact with a New Zealand doctor. An example of this is from a Taiwanese woman (CT18): “because I applied from immigration for PR, so we have to get from doctor to check my body, so go soon”. This woman did not otherwise go to the doctor very often in New Zealand, as she is “health” (CT18).

A number of participants indicated they had brought medicine with when they moved to New Zealand and, as a consequence, did not need to go to the doctor, or did so after the medicine had run out. One Chinese woman (C20) told she had only recently gone to the GP for the first time after living in New Zealand for eight years “because I take medicine from China, lot of medicine, but it finish, then I see doctor”. Also, a Taiwanese man (CT02) indicated that he had brought prescription medicine with him from Taiwan and thus had no need to visit a GP. He went to Taiwan often for work and during such visits was able to renew his prescription.

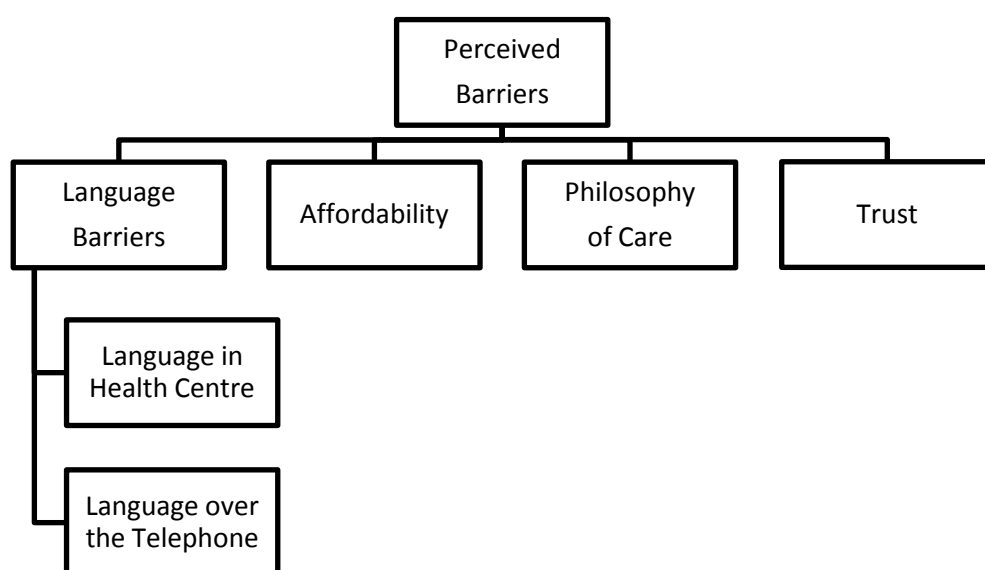
However, a number of Chinese participants spoke of needing to visit large clinics/hospitals to see the doctor, waiting long periods and not always being able to choose which doctor they saw. For one Chinese man (C39), in New Zealand for 2 years, the New Zealand GP was a vast improvement in terms of waiting times in the clinic. He said he had to

go frequently to the GP for ongoing management of an acute health condition and did not mind needing to make an appointment first, as he felt this is what had reduced the waiting time for care in New Zealand.

The patterns of utilisation of health care in New Zealand were influenced by the differences in how health care was accessed in participant's countries of origin. Differences included systems of care delivery, medicinal access and changes in costs. Frequently, low use in New Zealand was also related to a continuation of or improved good health after migration.

### 6.3 Perceived barriers to health care in New Zealand

During interviews participants indicated a number of issues that limited and influenced their access to, and utilisation of, health care in New Zealand. These include language ability, affordability, philosophy of health care and trust, which are displayed in Figure 6.2. Philosophy of care is the beliefs and approaches to the provision of health care, how and when services and treatments are provided and to who. Frequently, philosophies may differ between countries. Trust is the ability of a patient to have the assurance and confidence in the health care provided, that it is the most suitable for them.



**Figure 6.2:** Perceived barriers to access, and the utilisation, of health care.

### ***6.3.1 Language as a barrier to accessing health care***

*Language is the biggest problem. We can get by in normal life, but not with the medical things (C34).*

Language was the barrier to the utilisation of health care most frequently reported as being an issue for the participants in gaining appropriate health care. Language as a barrier to health care access is well documented and was an issue that crossed the three participant cultures and ethnicities. The language barrier was presented in two particular contextual sub-themes: within the physical health care setting and on the telephone.

#### ***Problems with language in the physical health care setting influencing utilisation***

A common theme within the wider barrier of language reported by the interview participants was the nature of language used by doctors when visiting a health or medical practitioner. Although participants found the use of English in everyday settings to not be an issue, the use of medical terms created a barrier to adequate care. A Chinese woman (C46); “Talking to her in English is no problem, but medical is very difficult”. A Chinese woman (C22) “some professional word we don’t know, the talking is too hard is the body word”. A Chinese woman (C34) stated “some particular words don’t understand”. One participant, a Chinese woman (CM24), reported she did not have trouble at her regular primary health care provider as the GP could speak Cantonese, her native language, but had trouble if she had to see a specialist at the hospital; “sometimes, if I go to the specialist and sometime I can’t understand the medical words”. For, a number of women, Chinese and Korean (C42, K42, K29), the speed at which the doctor spoke was an issue as they all agreed that “the doctor speaks too fast”. This speed of speech, connected to having to communicate in a second language, exacerbated the language barrier. Ironically, one of the participants indicated that while her GP was ethnically concordant, language barriers remained.

Due to the limitations of English language among some of the participants, one issue that emerged was the use of children in assisting with a doctor visit. This occurrence was a particular one for Mainland Chinese people with not only younger children (minors) translating for their parents during a consultation, but also for older children with higher English ability, or those who had been in New Zealand longer than their parents. A Chinese man (C36) who had indicated that he had been taken by his daughter to the doctor a short time after arriving in New Zealand, noted “my daughter said everything and I didn’t say anything”. He was not concerned about his daughter doing this as he had only just arrived in the country. He had not gone to the doctor since as his health was “good” (C36). Another older Chinese woman spoke of the GP speaking only to the daughter and not to her, which caused some consternation. This may be an issue connected to family members helping with translation. However, for one Korean woman this direction of interaction had also been her experience with a translator at the hospital. For one older Chinese woman (C34), in New Zealand for 6 years, the need to have her son help her put pressure upon her to seek health care from a Chinese speaking GP instead of seeing the New Zealand/European doctor she preferred:

...my son took me to see a Kiwi doctor and his attitude was better than the Chinese doctor, but I cannot rely on my son every time, so I changed to the Chinese one. I think the New Zealand one’s attitude is better, but because of the language and my son I have to choose.

Not wanting to create additional responsibility for her son limited her own ability seek health care on her own terms, however constricted they may be by his lack of independence through language.

Two women voiced a requirement to take their parents to the GP. A Chinese woman felt it was a part of being a daughter to them as they had moved to New Zealand to look after her children. In the situation found here an older child must find time to assist their parents in accessing health care. One, a Chinese woman (CM27) did not find this duty a burden; "...my parents, they are here, they use the GP I used before. And every time they go to the GP I have to go with them. It's no problem for me". This woman was aware that Chinese speaking GP existed in Christchurch, but the distant location of the surgery made it difficult to access. Thus, as these two immediate examples show, there is more than purely having language as a communication barrier to accessing health care. Language also influences and impacts on a wider social structure. A Korean woman (K48) was not so sure that translating for her parents was good; "terms and technical words, I had to explain to the doctor and then translate what the doctor had said to me, I wasn't very confident with it, I couldn't translate what he or she meant one hundred percent".

Helpful for a number of participants in terms of health communication understanding was those doctors who took the time to not only explain their illnesses and treatments to their patients, but also to listen to their patients. Explanations that were preferred by the participants were generally for the causes behind ailments and reasons for prescribed treatments. For example, for a Chinese woman (C22) indicated the GP; "speaks very slowly so I can understand. He is very patient". A Korean woman (K72) also told how the doctor "doesn't talk fast and explains everything so I understand".

### ***Language on the telephone as barrier to accessing health care***

On occasion speaking to health care staff on the telephone is required. This may be in order to make an appointment to see the GP, or to receive results of tests. Due to language, a number of participants found calling a GP clinic to be particularly challenging. Whilst some found the process of making an appointment not overly difficult, others found calling for



other health related information more so. Asking about important matters was more challenging than in a regular face-to-face consultation and thus was often avoided. A Chinese man (C36) stated; “sometimes I want to go there and talking on the phone, if in English is so hard to understand, so hard ... if booking it is okay, if talking which doctor you want to see, which part your body is hurt I don’t know how to explain”. A Korean woman (K64); “sometimes she, the reception, is very fast on the telephone”.

One Japanese woman (J47) limited her telephone contact with the GP clinic to a minimum. “I hate telephones. I don’t talk about important things over the phone. Just to make a booking is OK”. In addition others avoided calling whatsoever and had other family members make the call to the clinic for them such as a Korean woman (23) who stated that “[I] never call, my husband calls, clearly my symptoms I can’t explain”. One Korean woman (K64) felt the receptionist should have better understanding of her language needs when she called. “When I say my name she should know I have trouble”.

Many of the participants indicated they were unaware of their rights to an interpreter and were ignorant of the fact they could expect or ask for an interpreter upon request. Moreover, there was a widespread lack of awareness of the existence of any interpretation service amongst the participants, indicating the dissemination of information related to interpreter services was inadequate within health centres or GP clinics.

### ***6.3.2 Affordability as barrier to utilisation of health care***

The cost of a visit to a GP was frequently cited as a barrier to access by participants. Attached to this cost of a visit to the GP was the extent of services provided, such as blood tests were performed) and the outcome of a visit (for instance a prescription for medicine being provided). The cost barrier was common across all ethnic groups interviewed. A Chinese man (C37); “it is very expensive here and I have no income here and I feel it very

expensive to visit a doctor”. Similarly a Japanese woman (J2) stated; “just the first visit to see the doctor cost around thirty-five to fifty dollars, I think it’s pretty expensive”. A Japanese woman (J26) indicated; “we go less here because of the cost “.

For some of the participants the lack of access to health care due to cost may be as a result of lower socio-economic status. One Chinese woman (C34), in New Zealand for one year, who reported was only able to have one ailment treated per visit caused him to voice complaint. By only being able to have one ailment treated required him to return on another day to have these treated. This practice of treating one ailment per visit may be reflective of an individual GP’s practice and not indicative of New Zealand health care in general;

...each doctor costs forty dollars, and each time I go to see the doctor I have many things I want to talk to the doctor about, but the doctor says one visit for one disease, only a half hour visit so must come back tomorrow (C34).

However, for many others the perception of the cost of a GP visit as being expensive was influenced by the lower costs they had experienced in their previous countries of residence and to the presence of the public health insurance in these countries. A Taiwanese woman (CT18); “very expensive, Taiwan is very cheap, Government insurance; very nice”. A Japanese woman (J2); “we have the national insurance, much cheaper to go to doctor”. Many of these people still went to the doctor if the illness was perceived to be serious enough.

A visit to the GP that resulted in a referral to a specialist was voiced by participants to be an issue of cost. In some instances this complaint about cost was frequently directed towards the GP, not the specialist themselves, and the need to get a referral. “I pay forty dollars for seeing the GP, plus twenty dollars just for letter”. Attached to this aspect the barrier of cost is the perception of a lack of value for money if no prescription was obtained

by the patient. Part of this dissatisfaction is related to the philosophy described in the previous chapter of the decreasing trend in antibiotic use in New Zealand. A common response from many of the participants was towards the method of treatment that involved the recommendation of Panadol, something which is easily available from a supermarket and does not require a prescription to purchase. In addition, the way in which a doctor will only offer advice also caused dissatisfaction, resulting in patients being disinclined to see a doctor if they were unwell because of the cost. A Japanese woman (J11);

...in New Zealand we don't get medicine the same, and it costs a lot just to visit the doctor and there are so many illnesses, so how can Panadol cure so many illnesses. That is something you can get from the pharmacy or supermarket, so it isn't anything special.

A Taiwanese woman (CT19) had a similar opinion to only consulting and not receiving any tangible treatment from a specialist; "just talk, just consult. Maybe twenty to thirty minutes and he doesn't do anything and I pay about [\$180 to \$190]".

A Japanese woman (J26), resident in New Zealand for 16 years, indicated that she had gone back to Japan for surgery due to the barriers of cost associated with private health care in New Zealand to avoid the waiting list for elective surgery in the public system.

...if we have a bigger health issue it costs much more here, so we go back to Japan as it is much cheaper, even with the airfare. Last time I went back I had to have a mole removed, it was getting painful and it could be cancer. I went to see the doctor here and it was going to cost so much, it was going to cost \$5000 as I don't have any insurance here, and couldn't go to the public system, as I had to go to the specialist and he gave me a quote, so I had it removed for about \$30 in Japan.

For this woman the costs and inconvenience of returning to Japan far outweighed the cost barrier she encountered in New Zealand. These examples demonstrate the causes for going home are numerous. Affordability, accessibility with culture and language, and timeliness of care availability all caused participants to return to their home countries for differing forms of health care.

### ***6.3.3 Differences in the philosophy of health care as a barrier to utilisation***

As discussed in the previous chapter the philosophy in how health care is provided can differ from that of the migrant's home country and experiences of the difference can influence how a migrant will perceive care in the new country and influence utilisation. The existence of a GP is not a common feature in many Asian countries including Japan, Korea, Taiwan and China. Many participants indicated that the idea that a family, or other family members, routinely going to the same doctor or clinic was very uncommon with people generally seeing a different doctor each time. Points of difference that affected participants' utilisation of health care included: GP based care and the need for a referral to see a specialist, and available treatments. As many of the examples recorded will show, the length of time in New Zealand (acculturation) had little difference upon the participants' feelings towards using a GP or how care was delivered.

For many of the participants an inconvenience to accessing health care was the process of needing to consult a GP before being able to move on to a specialist. It is common practice in these countries to seek health care from a specialist in the first instance with patients often visiting specialists in a larger hospital directly without any referral from a GP. Indeed, many participants pointed to the non-existence of GPs in their countries of origin. Japanese and Korean participants told of the presence of many smaller private specialist clinics that they would visit in place of specialists in a large hospital. These participants also

pointed out that in most instances it did not cost any extra to visit these smaller specialist clinics. A Chinese man (C22), resident for 4 years in New Zealand said that “in China if your body, different part of body there is professional doctor not like here has a family doctor, he can see from your head to feet, but in China different doctor for each”. A Korean woman (K23), in New Zealand for 13 years:

we don't have the GP system, we have many specialists and we can go there if we want, if we have eye problem, eye doctor, even obstetrician and ear any kind of specialist, we can go, we don't have the GP, very easy.

A Korean woman (K16), who had been in New Zealand for 11 years, felt time to be a problem with the need for a referral; “can't go directly to the hospital, always go to the GP first, and then specialist, then hospital. It is very time consuming”. For a Taiwanese woman (CT19), one year in New Zealand, the need to go to different locations created inconvenience for her; “I think in Taiwan it is more convenient than in New Zealand than the GP system, because we have to go, go there, and then go there”. Having to go to the GP in the first instance before seeing a specialist created annoyance for her; “too many things even the GP to the specialist and then we can go to the specialist and we have pay money for the GP to write the letter. And wait for the specialist information and then we can go”. Connected to this was the added cost of the referral letter creating a further barrier attached to the referral system in New Zealand. However, one Japanese man (J50), resident in New Zealand for 8 years, found things simpler by being able to go to the GP first, as in Japan “we have to go to the specialist, we have to look for the specialist, we have to research a lot of things, it's confusing”.

The philosophy of care experienced between countries influenced the perception of health care in New Zealand. For many of the participants the common practice of yearly health checks caused a perception that health care is responsive and not preventive in New

Zealand. A Japanese woman (J6), 7 years in New Zealand and who had been a nurse in Japan, felt there was;

...different thinking from Japan and New Zealand I think the difference between Japan and New Zealand because in Japan before we sick we just try to find. Every year we can check before getting sick, but in New Zealand we are got sick starting medication.

Thus, there remains a perception that health care in New Zealand is lacking and inadequate to an extent for her. With the view that preventative screening, or “health checks” as so many participants term it, is not carried out in New Zealand to a sufficient level compounded the perception of health care as being too late in this country. A frequent comment and concern from female participants across all ethnicities was the infrequency of cervical cancer and breast cancer screening in New Zealand. There was common desire for these screening tests to be carried out every year as there was available to them in their countries of origin. A Taiwanese woman (CT24), 30 years in New Zealand, said that “in Taiwan we can go every year for the test”. A Japanese woman (J2) “that’s a problem because in Japan we can go every year for test, but here its every 2 or 3 years unless we pay extra. It would be better if it was every year; you never know what’s going to happen in 2 or 3 years”. A Japanese woman (J74) “our town provides woman’s checks every year, so we go, it’s good to test often, but here we don’t get them, more is better”. These women indicated they did utilise the screening available in New Zealand, but the perceived infrequency of testing had a negative influence upon them towards health care in New Zealand as being more one of response than prevention.

For a number of interview participants differences in the treatments previously received and then that available/received in New Zealand affected the extent to which they valued the care in this country. The expectation of a pharmaceutical solution lay at the centre of this perceived lack of value in New Zealand GP care. Similarly, a Japanese man (J50)

stated that “in New Zealand we go to the doctor we don’t really get an injection or drip as I expect, I haven’t got any antibiotics, but they say just lots of water”. Similarly, a Korean woman (K70) spoke of receiving an IV drip when sick in Korea “it takes an hour or so and we usually get better quickly, but in New Zealand it really takes a long time”. Thus the perceived requirement for a medical, pharmaceutical solution to illness leads to a perception that New Zealand GP care is lacking in the level of treatment.

A number of participants, particularly from mainland China, found satisfaction in the New Zealand health system in comparison to what they had experienced in their own countries. For the mainland Chinese interviewed the indicated satisfaction was related to the appointment waiting times in their GP clinic and the time spent with the doctor during a consultation. A Chinese woman (C40), “better than China, we must wait a long time to see the doctor. The whole environment, medical environment, is better here than in China”. A Chinese man (C36):

...it’s much better than in China. If you want to see the doctor in China there many people and the doctor can only spend a little time with you and cannot ask any question so here is much better than in China. The appointment was at 9 o’clock, it was amazing; I could see the doctor on time.

Others were satisfied with the way in which New Zealand GPs explained about their symptoms or aspects of their ailments and gave advice about treatment. A Japanese man (J06) “they listen quite a lot, they don’t come to the conclusion before I stop talking it’s quite good and they will explain in an easy way the three doctors I have seen”. A Korean woman (K25) was “very happy” as the doctor “explained things very clearly, in Korea they never do that”. GPs taking the time to listen, allowing the patient to explain in their own time, lead to increased positive perceptions of health care.

### *Trust as a barrier to the utilisation of health care*

An ability to trust the GP or other health practitioner was a common theme in determining utilisation of health care amongst the participants. Those participants who spoke of distrusting their doctors in New Zealand did so from experience and resulted from the poor care they had received. Where trust with doctors was in evidence, it has stemmed from a relationship built with the participant's GP, through the manner of the GP towards the patient.

For a number of women participants the health care received for their children led to distrust, which in turn caused these women to seek care elsewhere, but not in New Zealand. For one Japanese woman (J7), resident in New Zealand for 7 years and a former nurse, the distrust she held towards health care in New Zealand stemmed from the proposed treatment of her at the time 2 year old child's hip problem. She sought care for her daughter after migration and after having received advice from a specialist in her own home country. Bringing the medical records from Japan:

I went to doctor in Christchurch hospital for specialist, I gave to them. And then he read the sick name, he just says, 'ok, it's operation', he looks at the x-ray, but I know it's the other way; he is looking at it the wrong way. I can't trust.

Contrary to what the Japanese doctors had recommended due to the child's age (waiting until the child was 5 or 6 years old), the consultation with the specialist in New Zealand led to placement on the waiting list for surgery against her wishes. The mother refused the operation resulting in CYFS<sup>13</sup> "call[ing] us, and we said because we didn't trust, because I needed more information. I understand medical things, I studied a lot, but... when I go to Japan I take her to see the doctor". The experience in New Zealand led to her to distrust health care provided in New Zealand causing her to seek care elsewhere.

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<sup>13</sup> CYFS is Child, Youth and Family Services, and agency of the New Zealand Government directed to protect children. Pronounced, and commonly referred to as, 'siffs'.



The poor experience was repeated with a Japanese woman (J52) who told of visiting a GP for the first time since migration after a miscarriage and was;

...really sick, I was so sad because mentally I was sick physically a little bit shocked, very sad, I was, (whisper) I had a miscarriage, so I was so sad of course, so shocked. The first time I got pregnant and the first time got I have to go the GP... And then I was so, lot's of pain, I couldn't even sit down so painful thing I had to experience. I already told him that condition I was. He just talked to me like just he told me the survey, the numbers. 'Ok maybe your age, how many percent to have the risk. Just number, number, number to me. I didn't really want to hear, listen to his story his survey. Just, treat me or something, do something. I don't want to sit down here. And I don't want to your number don't help me. I just want to lie down or. You know in Japan, maybe you know you've been there, you that I'd go to Japanese clinic they do something, maybe just 'Lie down here. What happened? Are you OK? Maybe just better to lie down'. But, just sit there, and listen to his story, his number, in the end I just had to get out of there.

For a woman from Taiwan (CT19), in New Zealand for one year, after seeking emergency antenatal care from her husband's family's GP because of some bleeding was asked to get an ultrasound:

...after I did the ultrasound that report gave me some recommended, that recommend was mistaken, it was old form the radiologist used and when I got the new form I didn't need the treatment, strange, can't trust

After her son was born CT19, whose Taiwanese husband's family had been in New Zealand for 20 years while she only one year, her distrust of the GP continued as the GP was not always sure of the problem with her son;

...doesn't know why he has some fever and the GP gives him some paracetamol and then what condition he will have a few days past and he don't get better and the GP will do another test and see if another part of his body has some problem.

This perceived uncertainty in the treatment of her son caused her to voice "I go to GP here, but if I can go to Taiwan, I go to the doctor too". Experiences of the health care in New Zealand led to distrust for these participants, causing disinclination towards utilisation.

One Taiwanese woman (CT8), in New Zealand for 10 years, stated during the interview she had been asked by her doctor a question that she felt to be culturally insensitive. "I thought was quite insulting. In Taiwan, I mean over here you have partners staying together right, not married couple, so this doctor asked me 'have you been changing partners?' That is quite insulting to me. I am married women; I stick to one". The question asked may be aligned with regular lines of questioning to patients in regards to sexual health, but for this participant from another culture such a line of questioning was not the norm. The participant felt the doctor, despite being a female doctor, should have been more considerate towards her as a married woman and had a better understanding of cultural norms amongst Asians. This incident had caused her to not go to the doctor as often in New Zealand out of concern towards how she would be treated. Not in a 'racist' way, but treated in a New Zealand/European manner without considering she is not.

However, despite these negative opinions of health care in New Zealand a number of the participants felt they could trust their GPs which encouraged continued visits. This trust was built through how the doctor related to them, actions during consultations and the relationship connections made to that doctor. A Japanese woman (J21), in New Zealand for 7 years, reported "he isn't just our doctor, he is like a family member, he is a friend". For another Japanese woman (J03), resident in New Zealand for 18 years, after having been to a previous

GP the time the doctor spent with her during a consultation encouraged her to continue to see her, because:

... she listens carefully and also she's not... she takes more time than the previous doctor that's why I go back to her I tell her about my family's history and she takes notes that's why I feel I can trust her.

In addition to those participants who had experienced GP health care in New Zealand, one man from Taiwan (CT1), who was also a doctor in that country, felt he could trust doctors more in New Zealand. While from a friend's experiences of utilisation and not his own, during a consultation for a knee problem the New Zealand doctor had said he did not know what had caused the problem and had recommended waiting before treatment. Whereas, in "Taiwan the doctor, he will say maybe this or this, would try something anyway, which may do more harm, maybe mistake. So, I trust New Zealand doctor more, they are honest". The knee got better after a week and did not need further treatment. Ironically, despite this trust in New Zealand doctors, he was not enrolled with a GP in New Zealand as he still spent time in Taiwan practicing medicine himself.

#### **6.4 Responses in place to mainstream health care**

During interviews participants indicated they responded to the provision of health care in different ways. Responses described here include the use of alternate health care such Chinese traditional herbal medicine, and how participants were first introduced to New Zealand health care provision. The responses could be in reaction to perceived inadequacies of health care, but also to being introduced to the health system for the first time after migration. The response could be after having visited a GP or other health care practitioner, but also as a first instance form of treatment.

#### ***6.4.1 Use of alternate health care in New Zealand***

Six Chinese participants and one Korean participant indicated they utilised alternate health care solutions other than mainstream New Zealand healthcare. A number of alternate health forms are available in New Zealand including acupuncture and traditional Chinese herbal medicine. Acupuncture has been an accepted form of treatment in New Zealand for many years; whereas this has been less time of herbal medicine. Typically alternate health care use took the form of traditional Chinese herbal medicine either available through regular Chinese grocers or through specialist shops. The use of herbal medicine links to former health care practices and beliefs that have been carried to a new country of residence. The length of time participants had been in New Zealand appeared to have little influence in decreasing use of herbal medicine used in parallel with mainstream New Zealand health care or when this had failed the participants as might be expected with increased acculturation.

For the most part, use of traditional herbal medicine was most common amongst the Chinese interview participants. One Chinese woman (C20), in New Zealand for 7 years, told during the interview “now there is Chinese shop sell[ing] Chinese medicine, I think I buy sometimes if I am feeling sick, my stomach not well. I buy Chinese medicine I think is well”. A Korean woman (K16), in New Zealand for 11 years, “I go to the special herbalist store for treatment”. A Chinese woman (C24), in New Zealand for 30 years, told during the interview her husband “buys from Auckland for us, more choice there I think”. And, another Chinese woman (C34), in New Zealand for 6 years, told of how she;

...go[es] back to China and in New Zealand something can't fix me that well and I go back to Guandong, you know, near Hong Kong, and I go in there. And I don't know if they are doctor, they put some herbs and boil and I do for a couple of months and I feel better. After I can't stay for more than three months there, and they say they can send some medicine to me.

Three interview participants indicated the main reason they went to a traditional Chinese herbal medicine practitioner was because of the perceived lack of treatment and lack of satisfaction after having consulted a mainstream GP. A Chinese man (C36), in New Zealand for one year, told of the lack of medicine to treat a cold and his dissatisfaction with the treatment he expected to receive from a GP. “There is no medicine for cold, so Chinese herbal medicine will make me feel better, to improve the symptoms. Western doctor just tell me to drink water and rest and Chinese medicine will [help] me recover faster”. A Chinese woman (C44), 9 years in New Zealand, said she had been to the GP for a stomach ailment, but had been unable to find relief through a mainstream treatment. A Chinese woman (C22), in New Zealand 4 years, told “my stomach not well this doctor gives me some medicine and my stomach is not well, so now I go to the Chinese shop to get Chinese medicine, now is no problem”. Many of these participants are long term New Zealand residents, but their use of herbal medicine remains similar to those who have lived in New Zealand for a shorter time. Years lived (acculturation) in New Zealand would appear to have little influence on these individuals’ choosing to use herbal medicine.

#### ***6.4.2 Means to acculturation and uptake of health care***

Acculturation to the health care system of a new country can increase the utilisation of that health care system. The simple concept of length of time a migrant has resided is a commonly accepted means to acculturation and the uptake of health care. Interview participants were asked how soon after arriving in New Zealand they visited a doctor. However, time did not appear to be of any importance to how soon a participant visited a doctor, with most making their first visit within one year of arrival. Two other means, family and friends, to the understanding and utilisation of New Zealand health care were prominent amongst all three ethnicities involved in this study.

### *Family as influence on utilisation of health care*

Having a New Zealand member of the family had a strong role in influencing the utilisation of health care. This family structure not only represented an early entry point and guide to health care in New Zealand, providing a means to navigate through the unknown health system, but also to some extent alleviated the barrier of language. The influence of family on the uptake of health care was more common for female Japanese interview participants, which is reflective of the high number of Japanese women married to New Zealand men. The following are typical examples telling how New Zealand husbands introduced their wives to the New Zealand system, helping them to find and enrol with a doctor. A Japanese woman (J7), aged 46; “my husband is kiwi, so he told me everything. I understand, because I have to go often for my son”. A Japanese woman (J2), aged 47, told of her husband taking her; “maybe the real first time he took me to a doctor. For the first time, I didn’t know the system, he made an appointment for me, I went to the family doctor”. Also for a Taiwanese woman (CT19), as mentioned above, whose husband’s family had been in New Zealand for 20 years, going to the GP was easy with the family involved in the visits.

An alternate to the New Zealand wife/husband and migrant partner paradigm is co-ethnic family members introducing the participant to the health care in New Zealand. A number of the participants had got married to members of their own ethnic group out of New Zealand and had then moved to New Zealand to remain with their marriage partner. In all examples within this research the relationships structure around a male having been in New Zealand and bringing his wife to New Zealand. This ethnically concordant marriage and subsequent migration to New Zealand, the partner’s regular country of residence, in turn lead to guidance through the New Zealand health care system. However, for a number of participants this mode to understanding the health system did not always lead to satisfaction with the GP.

### ***Friends in New Zealand community as an influence on health care use***

For some interview participants friends or other acquaintances assisted in helping to understand how health care works in New Zealand. One Chinese woman, (CM27), aged 53, who had worked in the international language student/tourism industry and met New Zealanders on a day-to-day basis, remarked; “because I always deal with kiwi, they go to GP, so I go to GP”. For a Japanese man (J11), aged 36, his employer had informed of the need to find a GP in New Zealand. “My employer told me. He told me about the NZ system, to register with a GP not to just go to the hospital”. One Japanese woman (J03) learnt from both her home-stay and from publications. “I found out about the New Zealand in a working holiday book and about health system in New Zealand and that you had to go to the GP first and from home-stay family”. This participant told she was enrolled with a GP, but did not go often as she was rarely ill. Many of the Japanese interview participants indicated they understood something of the New Zealand health system before migrating here. This occurred because of publications available in Japanese in Japan, which helped lead to early understanding of the health system in New Zealand.

### **6.5 Responses out of New Zealand to experiences and perception of health care**

Although all of the respondents in the study were entitled to use health services around half of the respondents had at some point returned to Asia to seek health care treatment. Many took the opportunity of being ‘at home’ (piggy backing) to have a series of preventative health checks. However, in other cases some respondents had postponed surgery and other treatments until going back to Asia. In all cases this response entailed a trip to their country of origin and never to a third country. There were two key reasons why participants returned to their home countries for health care. First, travelling out of New Zealand included countering the perceived barriers of cost of care in New Zealand and the inability to easily

receive the level of preventative health care they could expect in their countries of origin. With this last point ‘home country’ experiences remain in place for these participants, influencing how they will seek health care in New Zealand, to the extent of leaving New Zealand temporally. Second, for a number of the participants the timely, or lack of, accessibility to secondary health care led to a return ‘home’ for care.

#### ***6.5.1 ‘Piggy backing’ visits home with visits to the doctor***

A common practice among participants from Japan, Korea and Taiwan was to attach a visit to the doctor while they were in their home country for other reasons such as a holiday. Commonly this ‘piggy-backing’ of health care with a trip home was not for the specific purpose of a medical check-up or more urgent medical treatment, typically in response to a perceived inadequate availability and frequency of comprehensive health checks in New Zealand. This phenomenon was a feature across all three ethnic groups. A Taiwanese man (CT9) “went back to Taiwan 2 years ago. My mother passed away, and after that I went to a big hospital to get a full check up, a very thorough exam. Yeah, I had no problem, quite healthy”. A Korean woman (K46) noted; “usually when we go to Korea, we just have a health check and everything”. For a Japanese woman (J15), in New Zealand for 20 years, going to Japan for a health check-up was her main purpose to travel home, despite “we join it to a holiday, but the main purpose is to have the medical check. It is about \$10 in Japan. It is covered by the [public] insurance, to do everything”. These examples of travelling for a health check up were not related to any particular illness, but more for peace of mind and the inability to access such comprehensive testing in New Zealand.

For a number of participants wanting to go ‘home’ for care was related to follow post-surgery, but attached this to regular travel home on holiday. For example, one Taiwanese woman (CT31), who had lived in New Zealand for 17 years, had been diagnosed with a heart



condition immediately prior to her intended move here. After receiving a surgical procedure in Taiwan she had received continued care in New Zealand from a cardiologist, but had never been completely satisfied with the level of care she had received. She felt the doctors in New Zealand were superficial in their delivery of care as “they just tell you something, but don’t make you feel confident. In Taiwan they give you more detail and show you the picture make you more confident and happy and make you understand what your problem is”. She showed concern at the medical technology available in New Zealand as compared to that in Taiwan; “[the cardiologist] told me ‘we don’t do this kind of operation in New Zealand’, so... New Zealand is little slow from Taiwan, because Taiwan has more cases”. This final point is an admission that the level of health care available and the experience of doctors may be reliant on the population of a country and the number of cases a larger population presents. Even so, she sought a check up from her doctor in Taiwan as she was able to receive treatment from the specialist in her own language and complete more than one issue in a single visit to the hospital. As she commented; “sometimes three or maybe four things a day, but here every time I get in the hospital only done one things”.

#### ***6.5.2 Response with the intention to receive health/medical care in home country***

For many of the participants across all three ethnicities who indicated they returned to their home country for health care they did so with the specific intention of receiving medical treatment. Reasons for doing so included the perceived lack of post-operative follow-up care in New Zealand, and cultural comfort in instances of surgery.

Frequently, the return to the country of origin was for a desired continuation of care post surgery. This was reported from a number of the participants from Taiwan and Japan. For a Japanese woman (J7), who had lived in New Zealand for 7 years and had a New Zealand

husband, not having continued follow up consultations after surgery with her gynecologist, as she would have had if in Japan, caused her to return to Japan for the check-ups;

...because I had an ovarian cyst. I had to have an operation here. He was very nice, he explained everything and I understand everything he did for operation, but after the operation doesn't have any check up. So, I like a follow up. He just say 'everything done, everything OK, you don't have to come back anymore'. I was a little worried, so I went back to Japan to have a check up. (J7)

Where the post-surgery care and health management would have then returned to the GP, for her "not [a] specialist", this woman would have preferred seeing the gynaecologist at the hospital as she would have at home believing this to be better health care. Home country health care practices remained central to her and others that voiced this concern.

A number of participants reported they returned to their country of origin with the intention of receiving surgery for an ailment that had been diagnosed in New Zealand. The reasons stated for doing so were multiple: language, cultural comfort and convenience. One woman (C37) when asked why she had gone back to China for an operation to treat her cervical cancer told of reasons of language and the structure of her family in New Zealand; "because my daughter was not here, only my son, and I could not speak English I need someone to take me and son is not convenient". For a Taiwanese woman (CT18) the primary reason to go to Taiwan for health care was language "because language is easy. We can say easily. We can speak Taiwanese, so language is the same it is easy". Two Japanese participants, a man (J47) and a woman (J49), both in New Zealand for 14 and 16 years respectively, said they would return to Japan for care if the treatment and recovery time were to be prolonged. Reasons for this intention were related to ease of language and the comfort of being treated in their own culture. "If it would take a long time to cure or for rehabilitation,

and have to go regularly then I would go to Japan, because Japan will be more comfortable”. “I will go back if am old and need treatment. I worry about language when I am old, it would be hard I think”.

For one Korean woman (K17), aged 63, the length of waiting in New Zealand to receive care for a diagnosed health issue caused her to return to Korea “and got a check up, because here too much waiting, waiting”. The waiting time in New Zealand for health services is well documented, particularly in the example of elective surgery where increasing access to such surgery is a national health target of the Ministry of Health. A Korean woman (K64) told she had gone back to Korea for the dentist “it wasn’t urgent as I could endure, so it made sense to do it there and I knew it was going to be cheaper, if I can stay on pain killers”. Returning for the dentist was a commonly reported phenomenon, particularly amongst Korean and Japanese participants. A majority of the participants indicated they thought New Zealand dental care was unaffordable and avoided going to the dentist because of the cost.

## **6. 6 Conclusion**

This chapter has reported the analysis from interviews with participants from the Chinese, Korean and Japanese communities in Christchurch. Most of the participants were enrolled with a GP having visited soon after arrival. Many participants seldom visited their GP, or did not go at all, due to healthiness. However, others pointed to not utilising health care in New Zealand due to barriers such as affordability, language and negative experiences that influenced trust of the New Zealand health care system. In many cases affordability was linked to a perceived lack of value for money, where no treatment or tangible outcome was received through a visit to the doctor, or from simply being too expensive. Language was indicated to be the most pressing barrier to accessing health care and could be an issue in the physical health care setting with health practitioners and over the telephone.

Participants' home country health experiences continued to flow into how they utilised health care in New Zealand. Differences in health care between countries could also function as a barrier to utilisation. Utilisation patterns could be similar to previous patterns due to healthiness, but patterns also decreased because of differences in health care delivery in New Zealand. Home country health care delivery remained important for many of the participants long after having migrated to New Zealand to the point where, when possible, participants often utilised both systems simultaneously.

## **Chapter 7 Conclusion**

### **7.1 Introduction**

This chapter concludes the thesis and summarises the findings that have been presented throughout this research. First, the overall objective and research questions that were stated in Chapter 1 are discussed. The second section summarises the key findings that have emerged from this research under a sub-heading of each objective. The third section forms the foundation of this chapter and under each research question; a discussion section will relate the key findings to previous research. The fourth section discusses limitations of the research. The fifth section identifies possibilities for future research stemming from this thesis. Finally, a concluding statement completes the research.

### **7.2 Key Findings**

The overall objective of this research was to investigate how Asian migrants' perceptions of health care in Christchurch, New Zealand influence their utilisation of health care. To meet this aim four research questions were posed:

1. How have the health needs of the Asian population in New Zealand been met by the health sector?
2. How do 'home country' health experiences influence health care utilisation?
3. To what extent do modes of acculturation have in influencing utilisation of primary health care?
4. To what extent do perceptions and experiences of health care create barriers to utilisation of health care?

Under each research question there is a summary of the key findings. These findings are discussed in relation to the wider literature on migrant health care and health care

accessibility. In light of each objective the key findings will now be discussed in turn focusing on how they relate to the wider literature on migrant health care and health care accessibility.

### **1. How have the health needs of the Asian population in New Zealand been responded to by the health sector?**

Five key themes emerged through this research. The health needs of the Asian population have been responded to at a varied level throughout New Zealand. There is language assistance for migrants seeking health care in New Zealand, but is underutilised. There were multiple views of health providers towards Asian patients' expectations of health care and on the use of health interventions and screening. There were varied views by health care providers on the methods used by Asian patients in response to health care in New Zealand.

#### ***Regional response***

Much of the response towards the Asian population and its health needs has been within the greater Auckland region, which is unsurprising given the greater proportion of Asian migrants settling in Auckland City. In other regions, services provided to Asian populations are more closely targeted towards specific need within sub-groups, such as South Asians, and not broad-brush funding to the Asian population as a whole. Understanding of the health needs of the Asian population is also more developed in the Auckland region through publication of a number of reports focused on the ethnic group living within this region.

### ***Provision of language translation/interpreting services***

Publicly funded health translation services are provided at no cost to patients and health practitioners. Services are available through face-to-face contact or over the telephone. Health providers reported that these services are under utilised by patients and clinics alike and ongoing research into why this is the case is needed. Moreover, a patient simply being aware of rights to an interpreter in legislation is not sufficient to overcome language barriers. A disinclination by GP clinics to utilise interpreter services due to in clinic time constraints also impacts on patients' ability to overcome language barriers. The lack of time available for interpretation service use in a busy clinic was an important factor in the use of translation services. System barriers to translator use have also been reported overseas (Hadziabdic et al., 2010), and can also impinge on other patients' waiting times if consultations run overtime due to translator availability, or not. Grubbs et al. (2006) reported a reluctance by health providers to use interpreters in clinics, but this was more a cost issue of having to hire staff or professional interpreters to meet need in an often small market.

Health promotion materials are often of limited availability in the language needed by a GP clinic to meet the needs of its enrolled patients. GPs interviewed were frequently proactive in translating health promotion material, either doing the translating themselves or having others do for them.

The question was raised as to what extent patterns of use are based on the characteristics of the doctor or medical staff available. Stated by a number of the health professionals interviewed in this research there was an indication that ethnic concordance was desired by patients, both for communication ease and cultural comfort. (Lee et al., 2010b). Asian peoples' enrolment and utilisation was high with those GPs of Chinese ethnicity or where a nurse was available who spoke the same Asian language.

### ***Views of health providers towards Asian patients' expectations of health care***

Health providers pointed out Asian patients expected to receive 'something' after a visit to the doctor, most frequently a pharmaceutical solution with this expectation stemming from their experiences of health provision in their countries of origin. Often this ran into conflict with New Zealand primary health practice of having moved away from such singular solutions to the management of illness. Indeed, with non-communicable diseases prevention is often more important than the cure (McCracken and Phillips, 2012), and becomes a central focus of GP based health management.

### ***Health interventions and screening***

Health concerns of particular importance for health care providers were around mental health, sexual health and the connected cervical cancer screening, and cardiovascular disease. Concern was raised by providers over the low utilisation rates of screening services in general, though cervical screening stood out. Consistent with work elsewhere (McDonald and Kennedy, 2007), the low use was suggested as being from social and cultural reticence to an admittance of sexual activity amongst certain sub-Asian ethnicities/cultures. Programmes are ongoing to increase utilisation of services by the Asian migrant population.

Mental health was reported to be of particular concern for the Asian community and that there is considerable social and cultural stigma towards mental health. Thus a willingness to discuss mental illness amongst Asian people which made diagnosis and treatment is problematic, consistent with provider views on Chinese mental health care use in Australia (Blignault et al., 2008). Education initiatives are carried out in migrant communities to lower negative perceptions of mental health and increase utilisation of services.



In relation to CDV particularly, it is common for funding provision to be directed towards early screening for the South Asian migrant population in response to increased prevalence in this population.

### ***Views of health care providers on alternate care methods used by Asian patients***

Recent years have seen an increase in the availability of traditional herbal medicine. The position of the mainstream health care sector in New Zealand on this form of health care was mixed amongst those interviewed. There was a consensus amongst health providers that knowledge of herbal medicine was incomplete causing limited understanding of how to balance with mainstream health care provision, thus the need for patient choice towards one or the other.

Response to those Asian patients returning home for health care was met with mixed opinions by health providers. There was an indication of concern with repeated medical tests causing harm where need for treatment in New Zealand stems from testing overseas, but treatments carried out overseas were not seen as a major issue for follow up treatment in New Zealand. However, issues of translation of medical records if in a foreign language was voiced as minor hurdle of treating

## **2. How do ‘home country’ health experiences influence health care utilisation in New Zealand?**

Experiences in the delivery of health care before migration had an important influence on the utilisation of health care after moving to New Zealand. The influencing experiences could be from the philosophy behind health care in terms of delivery systems and in treatment of illness, or from simply being in good health.

### ***Differences in health care delivery influencing utilisation***

How health care is delivered differs between many countries. For many participants' previous health care experiences before migration influenced how they responded to modes of delivery in New Zealand. The existence of GPs was frequently cited by participants as a perceived hindrance to health care being time consuming and costly. The inability to access yearly health checks easily as was possible in home countries was seen as poor health care practice/provision by participants. However, those from mainland China did find New Zealand health care timelier in relation to clinic waiting times to what they had experienced in China. However, previous studies (Han et al., 2007, Lee et al., 2010b) reported a lack of cultural practice of preventative care amongst Asian respondents, which differs from participants in the current research where demand for preventative care was high. The high expectation of public health services to provide services have been found elsewhere (Woolf, 2012) and the efficacy of multiple screenings have often been found to be overestimated by patients (Hudson et al., 2012).

This study has pointed to the conflict that can arise between provider and migrant patient in the expectations of health care. While this conflict can stem from the migrant patient's aforementioned previous experiences of health care and commensurate expectations, understandably health care providers can expect a certain amount of conformity and acceptance of a new health care system. Conflict could arise with health practitioners seeing Asian patients pursuing tests as unnecessary, often to the point of over-testing and, in an extreme, attempting to abuse the system. Practitioners did acknowledge the demand and expectation for health checks by their Asian patients' stemmed from past experiences. However, the seeming or perceived lack of such services by patients impinged on their needs for hope and safety in available health care and previous research has indicated structural barriers of such lack of system flexibility lead to decreased utilisation (McBain-Rigg and

Veitch, 2011). In the current study, participants' expectations of health care came to represent a barrier to acceptance of health care practices in New Zealand, frequently causing a search for care elsewhere.

### ***Patterns of utilisation***

Many of the participants indicated they were in good health before they migrated and rarely visited a doctor, if at all. Generally, this good health is consistent with other research on migrant health outcomes (Frisbie et al., 2001). The good health of the migrants flowed through into their level of health after migration influencing a low level of health care utilisation. Of those who frequently went to the doctor, both before and after migration, utilisation was linked to older age or reproductive health including child birth.

Patterns of enrolment with a GP in New Zealand were connected to knowledge of need to enrol and what enrolment entailed. In this research knowledge of need to enrol was connected to requirements elsewhere outside of any illness and in one case there was a patient unaware of being enrolled, or not, despite having consulted with the doctor. While only one case, it indicates that when need to enrol is unclear there is a need to explain and educate to ensure understanding of the health system.

### **3. To what extent were modes of acculturation important in influencing utilisation of primary health care?**

A number of modes to acculturation were apparent in their influence on utilisation of health care with time in New Zealand, the presence of a New Zealander in the family and having New Zealand connections having varied influence on uptake of health care.

### ***Length of time resident in New Zealand***

Similar to previous studies (Van der Stuyft et al., 1989), the length of time participants had been residing in New Zealand appeared to have little influence on their use of health care. Early utilisation was in many cases connected to need, such as child birth and the presence of pre-existing illnesses, while many continued to not utilise health services after many years in New Zealand. Japanese participants indicated they were knowledgeable of the health system prior to migration due to publications available in Japan, while other ethnicities did not indicate such availability.

### ***Family and friends***

The presence of a family member, either a New Zealander or someone who had lived in New Zealand for much of their lives, had a strong influence on the early introduction to and use of health care services. Family influences on health care uptake demonstrate the importance of social networks for migrants mainly as a result of fewer logistic barriers on settlement and greater exposure to language and the host culture. Similarly in Australia, Kelaher et al. (2001) found Filipina migrants with an Australian born husband appeared to experience less stress adapting to life in that country and fewer problems with their health and access to health services than those with a Philippines born husband.

## **4. To what extent do perceptions and experiences of health care create barriers to utilisation of health care in New Zealand?**

Analysis of the interview transcripts revealed a number of barriers stemming from having experienced health care that influenced and affected participants' utilisation. These were issues with language ability in accessing health care, trust towards GPs and other health

providers, the cost of health care and the response by Asian patients to health care provision in this country.

### ***Language as a barrier to accessing health care***

Language was the barrier to health care most frequently reported as being an issue for the participants in gaining appropriate health care. Language as a barrier to health care access is well documented in the research literature (Saldov, 1991, Terraza-Núñez et al., 2011) and was an issue that crossed the three participant cultures. Participants pointed to health and medical literacy specifically as a communication barrier to good health care (Zanchetta and Poureslami, 2006). Problems with language were reported as being both in the physical health care setting and over the telephone. Problems with communication over the telephones were associated with the speed of speech on the part of the health provider and an inability to indicate language ability over the telephone to them, something that has been found elsewhere in New Zealand with Pacific People migrants (Ludeke et al., 2012). The lack of communication over the telephone points to the need for greater cultural competency and early identification of communication needs, not just with health practitioners (i.e. doctors and nurses), but also amongst those coming into contact with culturally diverse peoples, through whatever medium.

### ***Trust towards health providers***

Experiences of health care lead to distrust of GPs which, in turn, impacted on continued utilisation of health care in New Zealand. Distrust in GPs stemmed from the unfamiliarity with the generalist role of GPs and a desire for the continuance of specialist based care to which the participants were used to. Such attitudes towards the retention of provider familiarity are similar to those found by Lawton et al. (2005) in Scotland where

Type 2 diabetes patients stated a preference for services they had already received, disliking change. A change in provider from hospital clinic to GP based care could lead, not only, to a less serious perception of the disease, but that care would not be to the same level of quality. In the current study, distrust of GPs was linked to a lack of assurance and confidence in proposed treatments and that treatment would actually be obtainable to a desired level from a GP.

Frequently distrust was connected to health care for children and reproductive health. Participants felt trust towards those GPs who were believed to be honest, providing the time to listen to their patients and explained ailments and treatments to a level the patient was confident. In an example presented in this thesis trust was linked to with the doctor being considerate of the patient's emotional as well as immediate physical needs. De Maesschalck, et al. (2011) have written of the importance of understanding a patient's emotions, which are not always spoken of directly and are often displayed through subtle cues and hints, something the GP must learn to recognise to better respond to patients needs. Emotions will be displayed in other ways by Asian patients, differing from mainstream New Zealand-European emotional displays, complicating the understanding of these cues and hints.

Those health providers that were perceived as patient and willing to take time to explain illness and treatment to the point their patients understood were viewed positively by participants. However, explanations of the statistics around an ailment were seen as pointless, unhelpful and not leading to good treatment. It is therefore important that providers communicate health information in a manner appropriate to the patient, understanding immediate needs. Quality of care also included receiving good explanations, having privacy protected, and being allowed to participate in the decision-making process. The importance of cultural competency is highlighted by this finding, in that one model of care will not fit all cultures (Andresen, 2001).

### *Affordability*

The cost of a visit to the doctor was seen as a barrier to use of health care and is well documented as such elsewhere (Penchansky and Thomas, 1981, Gellert et al., 1995). Participants' mention of cost as a barrier to accessing health care is in contrast to the National Health Survey (Ministry of Health, 2012), where the Asian respondents were least likely to report unmet need due to cost, despite Asian people being amongst the lowest income earners in New Zealand. That there is a difference between the current research and the National Health Survey may be related to how unmet need was asked in the survey as the importance of appropriate question phrasing has been highlighted elsewhere (Law et al., 2005). Complaint at the price could be from not receiving any tangible treatment from a visit to the doctor, and also as a comparison with costs of health care experienced before migration.

Many participants indicated they wanted more than advice and expected a treatment that worked quickly and effectively. For most this meant a comprehensive pharmaceutical treatment stemming from treatment practices received before migration. Participants' ability to receive a pharmaceutical solution, almost always from a doctor, and to seek care from a specialist directly before migration, in turn caused a negative perception towards care in New Zealand. While previous research (Lawrence and Kearns, 2005) has identified the pharmaceutical expectation of migrants/refugees, it was not seen as being a negative aspect as found in this study. Akhavan and Karlsen (2013) reported these expectation as assumptions made by practitioners, but were not mentioned by patient participants in their study. The philosophies behind health care system and service delivery created barriers to health care utilisation in New Zealand and represents how previous health care experiences can carry over into a new place of residence. For many of the participants from all three ethnicities home country health experiences remained for many years after migration, and were not easily replaced with New Zealand practices. Differences in socio-cultural contexts between

both home- and host-countries shaped health care strategies, interplaying with an individual's characteristics.

### ***Responses to the experiences of health care in New Zealand***

Two key responses to the health care available in New Zealand were identified in this study. Firstly, and limited to the Chinese participants in the study, there were some who indicated they continued to use traditional Chinese medicine after moving to New Zealand and was frequently used either in conjunction with mainstream health care or in place of. As in a United Kingdom study (Rochelle and Marks, 2011), a small number of participants also indicated they travelled for herbal medicine for reasons of cost and availability. The importance of plural health care resources for these migrants is illustrated by the continued use of traditional medicine by the Chinese and the returning home for health care by all ethnic groups. New Zealand mainstream health care never completely replaced home country health care practices despite the length of time in New Zealand or other modes of acculturation the migrants have recourse to use in accessing care. Maintenance of dual health care resources was also found by Van der Stuyft et al. (1989) where migrants in Belgium continued to use 'lay health care' long after migration with parallel use of Western health care, the latter often being seen as a supplement. In contrast, an American study (Xu and Farrell, 2007) found Asian use of traditional medicine was as a complement to mainstream medicine and was a result of the reported level of acculturation.

Secondly, it was common for many participants to return home at some point for various forms of health care as a reaction to health care in New Zealand. The desire to return home for health care was from a need for cultural security during treatment, but for many it was from the perceived lack, or infrequency, of preventative health screening. Participants indicated they frequently combined visits to the doctor with trips home. These research



findings build on work with Korean migrants to New Zealand (Lee et al., 2010a), in that returning home for care extended to the Japanese and Chinese participants, often for similar reasons. Returning home can indicate a strong cultural connection remains for the participants long after migration, but also indicates that when possible migrants are willing to utilise multiple sources of health care that they feel are suitable for themselves (Green et al., 2006).

The importance of plural health care resources for these migrants is illustrated by the continued use of traditional medicine by the Chinese and the returning home for health care by all ethnic groups. For the participants in this study New Zealand mainstream health care never completely replaced home country health care practices despite the length of time in New Zealand or other modes of acculturation the migrants have recourse to use in accessing care. Maintenance of dual health care resources was also found by Van der Stuyft et al. (1989) where migrants in Belgium continued to use 'lay health care' long after migration with parallel use of Western health care, the later often being seen as a supplement. In contrast, an American study (Xu and Farrell, 2007) found Asian use of traditional medicine was as a complement to mainstream medicine and was a result of the reported level of acculturation.

### **7.3 Discussion**

The study is the first in New Zealand to include Japanese separate from the 'Other Asian' ethnic group, and the first to report from Taiwanese as separate from the wider Chinese ethnic grouping in relation to health service use. Through the disaggregation of ethnic data this study has shown that differences do exist between the North Asian cultures in terms of their health care seeking practices and should not be viewed as a single cultural group. It would perhaps be beneficial to break away from large ethnically aggregated reports

such as that by Scragg (2010) and Mehta (2012). While these reports do disaggregate Chinese and South Asian migrant populations, the reports still contain all other Asian groups in an 'Other Asian' category. Asians come from a wide geographical area and differ greatly from one another in culture, language and history and it would be beneficial for authorities that a sub-regional report structure be employed and include separate reports for the North Asian, South Asian and South-East Asian regions. The cultural differences also point to the need for systematic ethnic recording below that of the Level 1 ethnic category.

The disaggregation of the three North Asian ethnicities has also extended and built on the understanding of health care seeking responses by migrants when a health system does not meet expectations. Returning 'home' for care has been less well explored in the literature as a response to perceived access issues after migration (Migge and Gilmartin, 2011, Gideon, 2011) with few studies exploring the response specifically (Lee et al., 2010b). Consistent with previous literature on migrant health care seeking strategies, home health care continued to play an important solution to participants' health care after migration. Experiences with health care could lead to distrust and a lack of confidence in public health services and travelling home could thus provide peace of mind and a greater sense of well-being. Following from Glinos et al. (2012) familiarity with home providers and systems formed the desired and expected level of care, but participants' expectations of care could encounter conflict with health care practices in New Zealand. The perceived limited frequency of screening services and health check-ups were of particular importance to participants across all ethnicities, which often stemmed from their prevalence at home. Particular importance needs to be paid to Asian migrants in regard to expectations rooted in former practices, with health practitioners taking time to explain reasons behind the limited frequency of screening tests and not assume migrant patients will just accept the new practices they encounter.

This study has added to geographical work on barriers to health care utilisation, which has tended to overlook a consideration of migration and culture as an influencing factor in accessibility. The results of the study have highlighted the importance of culture to the acceptability and accommodation dimensions of access to health care (Penchansky and Thomas, 1981). As noted in previous chapters geography's work on accessibility research has for the most part tended to consider distance and socio-economic factors and only to a limited extent culture (Gellert et al., 1995, Lee et al., 2010a). As seen in other disciplines (e.g. Jenkins et al., 1996, Ngo-Metzger et al., 2003) cultural factors are frequently an overriding factor for migrants in their ability to access health care in a new country of residence. Language factors are of course well cited in the literature outside of geography as representing an access barrier. This study has demonstrated the beliefs and approaches to the provision of health care, how and when services and treatments are provided and to who, frequently differ between countries leading to some distrust of the health system by the migrant. Cultural barriers are a result of place effects upon migrants. Place effects are not simply a causal pathway to illness, but also act upon how migrants utilise health care. Barriers to health care use are not simply a result of where a migrant lives, but also reflect where they have lived in the past and the current study has shown influences of place are never totally removed.

To counter these place effects, the study has highlighted that more work is required in the training of health care providers in cultural competency, a training that is sensitive to the disparity in Asian cultures. The diversity in Asian culture can be problematic for health care policy. Efforts to promote cultural competence in health practitioner training are necessary, but have been shown to be not always adequate. For as Johnson et al. (2004, p.267) have noted "relying solely on enhancing cultural sensitivity to improve health care is that it wrongly assumes... that culture is something concrete, static, and applicable to all members

of the group”. Thus, even within a single cultural group individual experiences will differ requiring a more careful sensitivity to individuals and not to assume one method of care will fit all. Assessing the needs of an individual patient in relation to their culture can provide practitioners with information that can lead to the development of more culturally sensitive interventions and medical care, while drawing on cultural assets and addressing potential barriers in order to ensure optimal treatment and outcomes. When the patient believes the health practitioner is listening, cares, and is providing the best health care, they will develop trust and be more likely to follow advice and be proactive about their own health.

In terms of aging and the use of primary health services, it is important for health providers to demonstrate an ‘environment of accommodation’, an environment that is culturally acceptable at a migrant’s younger age. This environment is important for acclimating migrants at a younger age to receiving health care from a GP, so that as the migrant reaches older age, with older ages associated health issues, receiving health care in this generalist form and not from specialists in the first instance becomes a natural one. Meeting the health care expectations of migrants, whether they are abstract or pragmatic can be problematic (Giuntoli and Cattani, 2011), but through spending time with new migrant patients, listening to their needs, will lead to health services that migrants want to utilise into later life.

This research also indicated the dissemination of the types of services available is in need of improvement. Health providers, both at the patient direct contact and the funding levels (i.e. PHO) stated services were available, but were underutilised by Asian people. At the same time, Asian participants indicated a desire for health prevention services, but felt they were unavailable in New Zealand leading to a negative perception of health care provision. Moreover, in Chapter 5 there was also an indication some health providers were also unaware of what services were available. This inadequacy in awareness indicates greater

effort is needed in advertising, in the specific languages, that provides the Asian communities with the information they need. This dissemination of information needs to be wider than internet based outlets.

In terms of the funding framework of primary health care in this country the inclusion of culture needs to be considered in the formula at a national level. While this study has reported that Asian people as a single ethnic group reside across all deprivation deciles, with a leaning towards the more deprived areas and despite being amongst the lowest income earners, their need in this regard is not appear as urgent as for Māori or Pacific people. Despite this apparent lack of need through socio-economic position, this study has demonstrated there is an aspect to Asian people that influences their utilisation of health care stemming from cultural history, identity and practices and to ignore these points would be negligent. Training in cultural competency can help inside the clinic during a consultation, but getting the Asian patient into the clinic to start with cannot be addressed in this manner. Funding that addresses the cultural needs of Asian people in New Zealand, creating an environment of trust and accommodation within the health services, in this country requires consideration in a more direct manner.

#### **7.4 Strengths and Limitations of the study**

The strengths of this study lay in the involvement of Asian community members in its development and implementation to ensure that it was carried out in a culturally sensitive manner. Many of the participants observed that it was a good experience to share their perceptions of primary care with the hope that they could contribute to the improvement of services for their communities. This observation by participants in the study highlights the importance of inclusion at all stages of the research process in creating a more robust geographical research on health service use. Geographical research must be one of ‘with’ people and not one of ‘about’ the subjects under consideration. The use of qualitative

research methods were important in providing a platform that allowed participants to contribute in their own words and manner, to overcome the barriers of language and reticence to speak of personal issues that also work to limit access to health care.

However, it is important to point out that the importance and usefulness of the findings within this study should not be overstated. There are some limitations which would affect their general applicability and usefulness. First, in terms of the scale, the thesis is based on a case study of three Asian ethnic groups in Christchurch. This may limit the applicability of the study to groups in wider New Zealand. For instance, that Auckland has greater resources to meet the needs of the Asian community may influence those people of the same ethnic/cultural groups' perceptions of New Zealand health care in different ways. Second, research participants were mainly users of health care and only a very small number were not enrolled with a GP. The research did not involve ethnic community members who had not been *able* to enrol for some reason and the thesis is poorer for this. Further research work is required to find these missing people.

## **7.5 Future Research Possibilities**

There is much capacity for research into specific migrant women's health in New Zealand. While there are a number of studies that have generally covered women in their scope, as most studies generally do and that have had a more specific inclusion of Asian women migrants (e.g. Lee et al., 2010), a search for female gender specific research into migrant health in New Zealand leads to the conclusion that there has been some neglect in this area of health research. This lack of specific female inclusion in New Zealand health research is important for as Lewis et al. in their discussion paper *Safe womanhood* pointed out some time ago "... women face different health risks, not just with biology, but with social and cultural practices as well as political and economic realities" (1994, p. 2).

There are future research possibilities in the exceedingly possible increase of Asian patients undergoing surgery in New Zealand. Appreciation of the cultural needs of Māori and Pacific People have become well understood, but those of Asian patients are still in need of attention to ensure culturally safe hospital care for these people.

Following on from the cultural needs of Asians undergoing surgery, as far as this researcher is aware there is no work on the wellbeing of recent Asian migrant patients in post-operative care in New Zealand. An area of interest may be the culturally specific dietary needs of post-operative patients and its role/influence on patient wellbeing, particularly those from a rice based diet where even the type of rice is important.

In relation to the cultural factors in geography health care research this study did not employ a quantitative measurement of acculturation beyond length of time in the most casual way. As stated Chapter 1, acculturation has tended to be ignored in geography research on health care utilisation and would be interesting for the discipline to move into this area of work. Perhaps one area of interest would be to explore the use of geographic information systems with scales of acculturation.

Finally, future research possibilities are available for old age health care, particularly for those in retirement homes. Cultural considerations will increasingly become important as more Asians come to require 24 hour nursing care. Assumptions that Asian traditional old age care practices will remain with adult children cannot be maintained as these systems of care are breaking down in countries of origin themselves and will flow through into new countries of residence. More so as younger family members take on the cultural practices of New Zealand, abandoning those of their migrant parents and older generations.

## 7.6 Concluding Comment

The Asian population of New Zealand is the fastest growing of any major cultural group. Until recently, both health service providers and researchers have generally minimised the heterogeneity that exists among Asian New Zealanders. This practice, while somewhat understandable given the low population levels in some ethnic groups, precludes the diversity in language and cultural practices that exists in this large part of the New Zealand populace. This research provides new insights into the drivers of disparities in health care use from the perspectives of Asian migrant populations and the health care providers. It explores those elements of health care service use which encourage a lack of service engagement among patients and how it impinges on efforts to promote greater patient support among practitioners.

In New Zealand, health services are available that specifically target Asian patients, but they are not uniformly available across New Zealand. This study has identified features of mainstream general practice services, as well as factors that migrants bring with them that act as barriers to accessing these services for Asian people. The study has identified some as strategies that can be implemented into various stages of the Asian patient's introduction into and then through the health system and health care to improve the availability and acceptability of these services. Patients, not only Asian people, need to be able to trust the health care they are being provided, that it will be there when and where they need it.

*...if you have something serious, something is happening to you and it is a worry and you have been carrying that worry for a while and when you go there and he can't help you that is not very satisfactory (K70).*



## Appendix 1 Participant Demographic

### *Chinese Participants*

<b>ID</b>	<b>Gender</b>	<b>AGE</b>	<b>Spouse</b>	<b>Years in New Zealand</b>	<b>Enrolled with GP</b>
<b>C1</b>	Male	58	Concordant	7	No
<b>C2</b>	Female	56	Concordant	10	No
<b>C6</b>	Female	49	Concordant	10	Yes
<b>CT8</b>	Female	51	Concordant	10	Yes
<b>C9</b>	Male	67	Concordant	20	Yes
<b>CT18</b>	Female	54	Concordant	6	Yes
<b>CT19</b>	Female	29	Concordant	1	Yes
<b>C20</b>	Female	57	Concordant	7	Yes
<b>C22</b>	Male	54	Concordant	4	Yes
<b>CT24</b>	Female	66	Concordant	30	Yes
<b>CM27</b>	Female	53	New Zealand	12	Yes
<b>CT30</b>	Female	59	Concordant	7	Yes
<b>CT31</b>	Female	61	Concordant	17	Yes
<b>C33</b>	Female	64	Concordant	7	Yes
<b>C34</b>	Female	53	Concordant	6	Yes
<b>C35</b>	Female	38	Concordant	3	Yes
<b>C36</b>	Male	67	Concordant	1	Yes
<b>C37</b>	Male	59	Concordant	2	Yes
<b>C39</b>	Male	66	Concordant	2	Yes
<b>C40</b>	Female	64	Concordant	1	Yes
<b>C42</b>	Female	71	Concordant	2	Yes
<b>C44</b>	Female	62	Concordant	9	Yes
<b>C46</b>	Female	65	Concordant	8	Yes

*Japanese Participants*

<b>ID</b>	<b>Gender</b>	<b>AGE</b>	<b>Spouse</b>	<b>Years in New Zealand</b>	<b>Enrolled with GP</b>
<b>J2</b>	Female	45	Concordant	10	Yes
<b>J03</b>	Female	47	Concordant	18	Yes
<b>J06</b>	Male	34	Concordant	7	Yes
<b>J7</b>	Female	43	Concordant	7	Yes
<b>J13</b>	Female	39	Other	9	Yes
<b>J15</b>	Female	43	Other	20	Yes
<b>J21</b>	Female	46	New Zealand	7	Yes
<b>J26</b>	Female	47	New Zealand	16	Yes
<b>J41</b>	Male	52	Concordant	22	Yes
<b>J45</b>	Male	34	New Zealand	9	Yes
<b>J47</b>	Male	53	New Zealand	14	Yes
<b>J49</b>	Female	48	New Zealand	16	Yes
<b>J50</b>	Male	37	New Zealand	8	Yes
<b>J51</b>	Male	43	New Zealand	18	Yes
<b>J52</b>	Female	46	Concordant	3	No
<b>J53</b>	Female	49	Concordant	13	Yes
<b>J54</b>	Female	42	New Zealand	5	Yes
<b>J56</b>	Male	36	New Zealand	4	Yes
<b>J57</b>	Female	37	Concordant	2	Yes
<b>J63</b>	Female	34	New Zealand	1	Yes
<b>J74</b>	Female	44	Concordant	5	Yes

*Korean Participants*

<b>ID</b>	<b>Gender</b>	<b>AGE</b>	<b>Ethnicity of spouse</b>	<b>Years in New Zealand</b>	<b>Enrolled with GP</b>
<b>K12</b>	Female	56	Concordant	15	Yes
<b>K15</b>	Female	44	Concordant	17	Yes
<b>K16</b>	Female	63	Concordant	11	Yes
<b>K23</b>	Female	56	Concordant	13	Yes
<b>K25</b>	Female	44	Concordant	13	Yes
<b>K28</b>	Female	45	Concordant	6	Yes
<b>K29</b>	Female	38	Concordant	3	Yes
<b>K32</b>	Female	58	Concordant	6	Yes
<b>K43</b>	Female	72	Concordant	14	Yes
<b>K48</b>	Female	43	Concordant	5	Yes
<b>K55</b>	Female	32	Concordant	6	Yes
<b>K64</b>	Female	36	Concordant	1	Yes
<b>K65</b>	Female	31	Concordant	2	No
<b>K66</b>	Female	36	Concordant	2	No
<b>K67</b>	Male	24	Single	14	Yes
<b>K68</b>	Male	20	Single	20	No
<b>K69</b>	Female	37	Concordant	6	Yes
<b>K70</b>	Male	43	Concordant	12	Yes
<b>K71</b>	Female	33	Concordant	1.5	Yes
<b>K72</b>	Female	34	Concordant	5	Yes

## **Appendix 2 Interview Guide**

### **Utilisation and access patterns**

Are you enrolled with a GP?

How often do you visit the doctor in New Zealand?

What other health providers have you visited in New Zealand? (e.g. Acupuncturist, reiki)

How far do you travel to visit this doctor?

How often did you visit a doctor in your country?

How do you decide to visit or consult with a health professional?

### **Perception and satisfaction**

Why did you enrol with this doctor?

Can you tell me about a time that you were ill and needed to seek medical care? I want to learn about your experiences.

If any, what problems have you had when visiting a doctor? (Receptionist/telephone)

What aspects of visiting a doctor in New Zealand did you find good/disappointing?

Have you ever experienced difficulties in getting the health care you desire or need? What would you like to see changed?

### **Acculturation**

How long were you in New Zealand before you enrolled with a doctor?

How did you learn about the New Zealand health/medical/doctor/GP system?

Where do you obtain information about staying healthy and preventing illness?

Have you returned 'home' for medical treatment? Why was that?

## Appendix 3 Interview Information Sheet



### INFORMATION SHEET

You are invited to participate as a subject in the research project: **The utilisation of health care services by Asian cultures in Christchurch, New Zealand.**

The aim of this project is to investigate the perceptions of health care in New Zealand held by Asians in this country and how these perceptions influence patterns of health care utilisation.

Your involvement in this project will be to participate in an interview which will take around 25 minutes. You are free to answer any questions without risk of penalty. You have the right to withdraw from the interview at any time, including the withdrawal of any information provided. The interview will be recorded on digital voice recorder.

The results of the project will be published in an academic thesis, but you may be assured of the complete confidentiality of information gathered in this research, your identity will not be made public without your consent. To ensure anonymity and confidentiality, the use of pseudonyms will be used in place of your name in any publications and identifying details will be stored securely at the University of Canterbury and destroyed after five years.

The project is being carried out by Stephen Ward. They will be pleased to discuss any concerns you may have about participation in the research project.

Stephen Ward can be contacted at:

**[stephen.ward@pg.canterbury.ac.nz](mailto:stephen.ward@pg.canterbury.ac.nz)**, or

**Stephen Ward, C/- Department of Geography, University of Canterbury, Private Bag 4800, Christchurch 8140.**

The project has been reviewed *and approved* by the University of Canterbury Human Ethics Committee. If you have any concerns about this research, contact the Human Ethics Committee at:

**Human Ethics Committee, Okeover House, University of Canterbury, Private Bag 4800, Christchurch 8140, E-Mail: [human-ethics@canterbury.ac.nz](mailto:human-ethics@canterbury.ac.nz)**

Thank you.

## **Appendix 4 Interview Consent Form**

### **Consent Form**

#### **The Utilisation of Health Care Services by Asian Cultures in Christchurch, New Zealand.**

##### **Introduction**

This research study is being conducted by Stephen Ward at the University of Canterbury to investigate the perceptions of health care in New Zealand held by Asians in this country and how these perceptions influence patterns of health care utilisation.

##### **Procedures**

You will be asked to answer a series of questions. The interview consists of ## questions and will take approximately 25 minutes. Questions will include details about your social affiliations, demographics and your own personal views and feelings about health care in New Zealand.

##### **Risks/Discomforts**

There are minimal risks for participation in this study. However, you may feel emotional discomfort when answering questions about personal health or beliefs.

##### **Benefits**

There are no direct benefits to you. However, it is hoped that your participation will help researchers learn more about how cultural influences affect attitudes toward health services.

##### **Confidentiality**

All information provided will remain confidential and will only be reported as group data with no identifying information. All data, including recordings will be kept in a secure location and only those directly involved with the research will have access to them. After the research is completed, the information will be destroyed. The use of pseudonyms will be used in any publications.

##### **Participation**

Participation in this research study is voluntary. You have the right to withdraw at anytime or refuse to participate entirely.

##### **Questions about the Research**

If you have questions regarding this research, you may contact Stephen Ward at **stephen.ward@pg.canterbury.ac.nz Tel: (03) 364 2987 ext: 8123.**

I have read, understood, and received a copy of the above consent and desire of my own free will and volition to participate in this study.

Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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